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ABSTRACT

Two hearings held on October 24, 1985, and April 29, 1986, produced testimony about two House bills on prevention and treatment of Indian juvenile alcoholism and drug abuse. These bills provide for (1) programs of instruction on alcohol and drug abuse in Indian schools in kindergarten through grade 12; (2) training about alcohol and drug abuse for school counselors and school boards serving Indian children, community health representatives, and Bureau of Indian Affairs (BIA) and Indian Health Service (IHS) personnel; (3) summer recreation and employment programs for Indian youth on reservations; (4) research on the number of juvenile Indians needing residential alcohol and drug treatment; and (5) comprehensive treatment in IHS facilities. Representatives Douglas Bereuter of Nebraska and Thomas Daschle of South Dakota, bill sponsors, presented background information on the extent of the problem and need for this legislation. BIA and IHS statements opposed enactment of the bills, citing funding problems, and programs or policies already in effect. Witnesses giving supportive testimony included 4 members of national and regional Indian organizations and 12 Indian high school students; the latter described drug and alcohol problems in their schools and communities. The document includes a report and 14 data tables on mortality rates and juvenile alcohol and drug abuse programs generated from data bases in the Alcohol Epidemiologic Data System. (SV)

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INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

HEARINGS

BEFORE THE

COMMITTEE ON
INTERIOR AND INSULAR AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST AND SECOND SESSIONS

ON

H.R. 1156

TO COORDINATE AND EXPAND SERVICES FOR THE PREVENTION, IDENTIFICATION, TREATMENT, AND FOLLOW-UP CARE OF ALCOHOL AND DRUG ABUSE AMONG INDIAN YOUTH, AND FOR OTHER PURPOSES

H.R. 2624

TO AUTHORIZE PROGRAMS FOR THE TREATMENT AND PREVENTION OF DRUG AND ALCOHOL ABUSE AMONG INDIAN JUVENILES

HEARINGS HELD IN WASHINGTON, DC

OCTOBER 24, 1985, AND APRIL 29, 1986

Serial No. 99-15
PART II

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INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

THURSDAY, OCTOBER 24, 1985

House of Representatives,
Committee on Interior and Insular Affairs,
Washington, DC.

The committee met at 10:15 a.m., in room 2203, Rayburn House Office Building; Hon. Jim Moody presiding.

Mr. Moody. The committee will come to order.

Today the committee will complete its hearings on H.R. 1156 by Mr. Bereuter and Mr. Daschle and H.R. 2624 by Mr. McCain. Without objection a copy of both bills and the reports of the Departments, when received, will be made a part of the record at this point.

[The bills H.R. 1156 and H.R. 2624; background information; and a section-by-section analysis follow:]

99TH CONGRESS
1ST SESSION

H. R. 1156

To coordinate and expand services for the prevention, identification, treatment, and follow-up care of alcohol and drug abuse among Indian youth, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 20, 1985

Mr. BEREUTER (for himself, Mr. DASCHLE, Mr. UDALL, Mr. YOUNG of Alaska, and Mr. WILLIAMS) introduced the following bill; which was referred jointly to the Committees on Interior and Insular Affairs, Energy and Commerce, and Education and Labor

---

A BILL

To coordinate and expand services for the prevention, identification, treatment, and follow-up care of alcohol and drug abuse among Indian youth, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Juvenile Alcohol and Drug Abuse Prevention Act".

TITLE I—INTER-DEPARTMENTAL AGREEMENT

SEC. 101. (a) Within 90 days after the date of enactment of this Act, the Secretary of the Interior and the Secretary of Health and Human Services shall agree by means of a memorandum of agreement to—

(1) coordinate the Bureau of Indian Affairs and Indian Health Service alcohol and drug abuse programs existing on the date of enactment of this Act and programs established by this Act;

(2) identify Federal, State, local, and private resources to combat alcohol and drug abuse among Indians;

(3) delineate the responsibilities of the Bureau of Indian Affairs and the Indian Health Service to coordinate alcohol and drug abuse-related services at the central, area, agency, and service unit levels;

(4) determine the scope of the Indian juvenile alcohol and drug abuse problem and its estimated financial and human costs;

(5) authorize the Bureau of Indian Affairs agency superintendents and education superintendents and the Indian Health Service service unit directors to enter into agreements described in section 102; and

(6) provide for biannual review by the Secretary of the Interior and Secretary of Health and Human Services of the agreement under subsection (a).

(b)(1) The Secretary of the Interior and Secretary of Health and Human Services shall consult with and solicit the comments of interested Indian tribes and Indian individuals and Indian organizations in developing the agreement under subsection (a).

(2) The agreement under subsection (a) shall be submitted to Congress and published in the Federal Register within 90 days of the date of enactment of this Act.

SEC. 102. (a) At the request of any Indian tribe, the Bureau of Indian Affairs agency superintendent, the Bureau of Indian Affairs education superintendent, and the Indian Health Service service unit director for such tribe shall enter into an agreement with such tribe to coordinate resources and services related to alcohol and drug abuse prevention, identification, treatment, and follow-up care.

(b) Such agreement shall—

(1) identify the responsibilities and referral resources of all agencies and programs providing alcohol and drug abuse-related resources or services within such tribe's service area; and

(2) be modified semiannually to reflect changes in the availability of resources and services related to alcohol and drug abuse prevention, identification, education, treatment, and follow-up care.

SEC. 103. The Secretary of the Interior, acting through the Bureau of Indian Affairs, and the Secretary of Health and Human Services, acting through the Indian Health Service, shall bear equal responsibility for the implementation of this Act in cooperation with Indian tribes.

TITLE II—EDUCATION

SEC. 201. Section 304 of the Indian Elementary and Secondary School Assistance Act (20 U.S.C. 241cc) is amended by—

(1) striking out "and" at the end of paragraph (1);

(2) striking out the period at the end of paragraph (2) and inserting in lieu thereof "; and"; and

(3) adding at the end thereof the following new paragraph:

"(3) the training of counselors at schools eligible for funding under this title in counseling techniques relevant to alcohol and drug abuse .".

SEC. 202. Section 423 of the Indian Education Act (20 U.S.C. 3385b) is amended by adding at the end thereof the following new subsection:

"(e) 10 percent of the fellowships awarded under subsection (a) shall be awarded to persons who are receiving training in guidance counseling with a specialty in the area of alcohol and drug abuse counseling and education.".

SEC. 203. Section 315(a) of the Adult Education Act (20 U.S.C. 1211a(a)) is amended by—

(1) striking out the period at the end of paragraph (5) and inserting in lieu thereof "; and" ; and

(2) adding at the end thereof the following new paragraph:

"(6) to provide alcohol and drug abuse counseling services to better enable Indians in need of such services to take advantage of educational and employment opportunities.".

SEC. 204. (a) The Secretary of the Interior shall require Bureau of Indian Affairs schools and schools operated under contract under the Indian Self-Determination and Education Assistance Act (Public Law 93–638) to provide a program of instruction regarding alcohol and drug abuse to students in kindergarten and grades one through twelve.

(b) Schools providing programs of instruction under subsection (a) are encouraged to emphasize family participation in such instruction.

SEC. 205. (a) The Secretary of the Interior shall—

(1) establish summer recreation and counseling programs for Indian youth on reservations;

(2) require such Bureau of Indian Affairs schools and schools operated under contract under the Indian Self-Determination and Education Assistance Act as he determines to be necessary to remain open during the months of June, July, and August of each year to provide adequate facilities for such programs; and

(3) provide, as needed, salaried coordinators for such programs.

(b)(1) In addition to the facilities described in subsection (a)(2), the Secretary of the Interior is encouraged to use public facilities, other than those described in such subsection, and private facilities wherever possible for programs established under subsection (a)(1).

(2) Facilities which the Secretary may use under paragraph (1) shall be used under such terms and conditions as may be agreed upon by the Secretary and the authority having jurisdiction over any such facility.

(c) The Secretary of the Interior shall coordinate any programs established under subsection (a)(1) with any other summer programs for Indian youth.

SEC. 206. The Secretary of Interior shall, within 120 days of the date of the enactment of this title, publish an alcohol and drug abuse newsletter in cooperation with the Departments of Health and Human Services and Education to report on Indian alcohol and drug abuse projects and programs. The newsletter shall be published once in each calender quarter and shall be circulated without charge to schools, tribal offices, Bureau of Indian Affairs agency and area offices, Indian Health Service area and service unit offices, Indian Health Service alcohol programs, and other entities providing alcohol and drug abuse-related services or resources to Indian people.

TITLE III—FAMILY AND SOCIAL SERVICES

SEC. 301. (a) Any training program for community health representatives funded under the Act of November 2, 1921 (25 U.S.C. 13) shall include not less than two weeks of training on the problems of alcohol and drug abuse and shall include instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome.

(b)(1) The Director of the Indian Health Service shall, either directly or through contract, make available training on the problems of alcohol and drug abuse, including instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome to—

(A) the Bureau of Indian Affairs Superintendent of Education (or his designee);

(B) the Bureau of Indian Affairs Agency Superintendent (or his designee);

(C) Indian Health Service service unit directors;

(D) Bureau of Indian Affairs social workers;

(E) Indian Health Service doctors, nurses, nurse's aides, and paramedical personnel;

(F) Bureau of Indian Affairs school personnel;

(G) personnel of schools operated under contract under the Indian Self-Determination and Education Assistance Act; and

(H) supervisors of emergency shelters established under section 402(c) of this Act.

(2) The Director of the Indian Health Service shall also offer, upon request, the training described in paragraph (1) to—

(A) members of school boards governing—

(i) schools operated by the Bureau of Indian Affairs;

(ii) schools operated under contract with the Bureau of Indian Affairs; and

(iii) public schools on or near Indian reservations and public schools in Oklahoma, Alaska, and California with significant numbers of Indian students;

(B) members of parent advisory committees of Bureau of Indian Affairs schools;

(C) members of child welfare protection committees serving Indian communities;

(D) educators at Tribal colleges which do not otherwise provide alcohol and drug abuse training to their personnel;

(E) Urban Indian Center counselors;

(F) home-school-liaison personnel funded under the Indian Elementary and Secondary School Assistance Act;

(G) Tribal Council members;

(H) Tribal court judges;

(I) Administrators of the Women, Infants and Children Program operated by the Department of Agriculture;

(J) personnel of public schools on or near Indian reservations and public schools in Oklahoma, Alaska, and California with significant numbers of Indian students; and

(K) any interested member of the Indian community.

(c) The Secretary of Health and Human Services shall, upon request, provide certification to any person who completes training under this title for the purposes of obtaining academic credit or certification at any post-secondary educational institution.

TITLE IV—LAW ENFORCEMENT

SEC. 401. The Director of the Bureau of Indian Affairs shall, in the training of Bureau of Indian Affairs law enforcement personnel, provide education on the problems of alcohol and drug abuse among Indian juveniles.

SEC. 402. (a)(1) Subject to paragraphs (2) and (3), any tribal, Federal, or Bureau of Indian Affairs law enforcement officer who arrests an Indian juvenile for any offense related to the abuse of alcohol or drugs shall, in lieu of incarceration, place such juvenile in a temporary emergency shelter described in subsection (c) or a community-based alcohol or drug abuse treatment facility to the extent such facilities are available.

(2) Paragraph (1) and any regulation promulgated under paragraph (3) of this subsection shall not supersede any tribal law.

(3) The Secretary of the Interior, in consultation with the Attorney General of the United States, shall promulgate guidelines under which a law enforcement officer may place an Indian juvenile arrested for an offense related to the abuse of alcohol or drugs in a facility other than an emergency shelter described in subsection (c) for the benefit of the Indian juvenile or the safety of the community.

(b) In the case of any State which exercises criminal jurisdiction over any part of Indian country under section 1162 of title 18 of the United States Code or section 401 of the Act of April 11, 1968 (25 U.S.C. 1321), such State is urged to require its law enforcement officers to—

(1) place any Indian juvenile arrested for any offense related to the abuse of alcohol or drugs in a tem-

porary emergency shelter described in subsection (c) or a community-based alcohol or drug abuse treatment facility in lieu of incarceration to the extent such facilities are available; and

(2) observe the guidelines promulgated under subsection (a)(3).

(c)(1) The Director of the Bureau of Indian Affairs shall establish a program and approve a compensation schedule under which households of Indian families will be compensated to serve as temporary emergency shelters for Indian juveniles apprehended by any law enforcement officer for offenses related to the abuse of alcohol or drugs.

(2) No emergency shelter established under a program established under paragraph (1) shall commence operation until—

(A) the tribal council of any tribe to be served by such shelter approves such shelter; and

(B) such shelter meets the licensing requirements promulgated by the Bureau of Indian Affairs under paragraph (3).

(3)(A) The Bureau of Indian Affairs shall, within 120 days of the date of enactment of this paragraph, promulgate standards by which the emergency shelters established under a program under paragraph (1) shall become licensed.

(B) Such standards shall require that any individual supervising such shelter have completed the training described in section 301(b)(1) of this Act.

(4) The costs of construction of any emergency shelter are not authorized by this Act.

TITLE V—JUVENILE ALCOHOL AND DRUG ABUSE TREATMENT AND REHABILITATION

SEC. 501. The Director of the Indian Health Service shall, within 6 months of the date of enactment of this Act, conduct a study to determine—

(1) the size of the juvenile Indian population in need of residential alcohol and drug abuse treatment;

(2) where facilities to provide such treatment are or should be located; and

(3) the cost of providing such treatment.

SEC. 502. (a) The Director of the Indian Health Service shall provide a program of comprehensive alcohol and drug abuse treatment services, including detoxification and counseling services, and follow-up care in Indian Health Service facilities and in facilities operated under contract under the Indian Self-Determination and Education Assistance Act to Indian juveniles and adults in need of such services.

(b) No health facility described in subsection (a) shall be required under this section to provide inpatient services if such facility is primarily an outpatient facility.

(c) The Director shall report on the progress of the program provided under subsection (a) to relevant committees of the Congress within 18 months after the completion of the study described in section 501.

SEC. 503. (a)(1) The Secretary of Health and Human Services shall, in consultation with the Indian Health Service and the Bureau of Indian Affairs, identify and utilize wherever possible existing federally owned structures suitable for use as residential alcohol and drug abuse treatment centers for Indian juveniles to meet the needs identified in the study under section 501.

(2) Any structure described in paragraph (1) may be used under such terms and conditions as may be agreed upon by the Secretary of Health and Human Services and the agency having responsibility for the structure.

(3) The Secretary of Health and Human Services may, directly or by contract, renovate any facility described in paragraph (1). Any such renovation shall conform with such terms and conditions as have been agreed upon under paragraph (2).

(b) The Secretary of Interior shall identify for the Secretary of Health and Human Services any existing Bureau of Indian Affairs facilities which could be utilized for residential alcohol and drug abuse treatment centers for Indian juveniles.

(c) If there is not an adequate number of facilities which may be renovated under subsection (a)(3) to meet the treatment needs identified in the study under section 501, the Secretary of Health and Human Services shall seek specific authority to construct such facilities as he finds necessary to meet such treatment needs.

TITLE VI—DEFINITIONS, EFFECTIVE DATE, AND AUTHORIZATION OF APPROPRIATIONS

Sec. 601. For the purposes of this Act, the term—

(1) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community of Indians, including any Alaskan Native village or regional or village corporation as defined in or established pursuant to the Alaska Claims Settlement Act (43 U.S.C. 1601, et seq.) which is recognized as eligible for special programs and services provided by the United States to Indians because of their status as Indians;

(2) "Indian" means any person who is a member of an Indian tribe;

(3) "juvenile" means any Indian under the age of 18;

(4) "service unit" means an administrative entity within the Indian Health Service serving one or more Indian tribes within a geographical area defined by regulation by the Indian Health Service;

(5) "service area" means the geographical area served by a service unit;

(6) "Indian Health Service area office" means an administrative entity within the Indian Health Service through which services and funds are provided to service units within a geographical area defined by regulation by the Indian Health Service;

(7) "Bureau of Indian Affairs area office" means an administrative entity within the Bureau of Indian Affairs through which funds and services are provided to agency offices within a geographical area defined by regulation by the Bureau of Indian Affairs; and

(8) "agency office" means an administrative entity within the Bureau of Indian Affairs serving one or more Indian tribes within a geographical area defined by regulation by the Bureau of Indian Affairs.

SEC. 602. (a) Except as provided in subsection (b), this Act shall become effective October 1, 1985.

(b) Titles I and VI and section 402(b)(3) of this Act shall become effective on the date of enactment of this Act.

SEC. 603. (a) There is authorized to be appropriated $5,000,000 to carry out the amendments in title II, the provisions of titles III and IV and the study in section 501 of this Act.

(b) There is authorized to be appropriated such sum as Congress determines to be necessary to carry out sections 502 and 503 of this Act after taking into consideration the findings of the study conducted pursuant to section 501.

○

I

99TH CONGRESS
1ST SESSION

H. R. 2624

To authorize programs for the treatment and prevention of drug and alcohol abuse among Indian juveniles.

IN THE HOUSE OF REPRESENTATIVES

MAY 23, 1985

Mr. MCCAIN (for himself, Mr. BARTON of Texas, Mr. BEREUTER, Mr. BLAZ, Mr. LAGOMARSINO, Mr. STRANG, Mr. UDALL, Mrs. VUCANOVICH, and Mr. YOUNG of Alaska) introduced the following bill; which was referred jointly to the Committees on Interior and Insular Affairs, Energy and Commerce, and Education and Labor

---

A BILL

To authorize programs for the treatment and prevention of drug and alcohol abuse among Indian juveniles.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of Health and Human Services, hereinafter "Secretary", is authorized and directed to formulate a program for the treatment of Indian juvenile drug and alcohol abuse and coordinate such program within existing general programs for the treatment and control of alcoholism and drug abuse. Wherever possible, the Secretary is authorized to enter into an appropriate agreement with the Secretary of the Interior to share resources, including field facilities. Such Indian Juvenile Treatment Program should include post-treatment counseling. The Secretary is also authorized to allocate existing funds or personnel of a existing or new program to designated "crisis areas" on an emergency basis, as determined in section 5 of this Act.

SEC. 2. The Secretary shall establish an Office of Indian Juvenile Alcohol and Drug Abuse within the Alcohol, Drug Abuse and Mental Health Administration which shall be responsible for integrating the provisions of the first section of this Act with the programs and authorities of the Department in the field of alcohol and drug abuse. The Office shall have assigned to it a number of full-time equivalent positions, which shall not number less than eight, and such other positions as the Secretary deems necessary. Through this Office the Secretary is directed to consult with tribes concerning implementation of the programs authorized by this Act.

SEC. 3. (a) The Secretary shall within one hundred and eighty days of the date of enactment of this Act, enter into an agreement with the Secretaries of the Interior and of Education to coordinate their Departments efforts and programs related to alcohol and drug abuse among Indian juveniles. The agreement shall provide for the identification and coordination of available resources and programs to address and treat Indian juvenile alcohol and drug abuse through prevention, education, counseling, and referral. The Secretary shall publish such agreement in the Federal Register within thirty days after an agreement has been entered into pursuant to this subsection.

(b) The Secretary, in consultation and in cooperation with the Secretaries of the Interior and of Education, shall develop a program to provide training in—

(1) the identification of juvenile alcohol and drug abusers; and

(2) prevent education (including drug and alcohol abuse), health promotion and disease prevention;

(3) counseling techniques on juvenile alcohol and drug abuse.

Such training shall be made available to elementary and secondary teachers and counselors—

(A) in schools operating by the Secretary of the Interior;

(B) in schools operated under contract with the Secretary of the Interior; and

(C) in public schools on or near Indian reservations (including public schools in Oklahoma, Alaska, and other States with significant numbers of Indian students).

The Secretary may provide such training either directly or through contract with qualified private or public entities.

(c) The Secretary of the Interior, in consultation and in cooperation with the Secretaries of Education and of Health and Human Services, shall review existing materials on juvenile alcohol and drug abuse, including studies and school curricula and any other material relevant to an understanding of the problem of juvenile alcohol and drug abuse, and shall make available the results of such review to the schools described in subsection (b).

(d) The Secretary of the Interior shall require Bureau of Indian Affairs schools and schools operated under contract pursuant to the Indian Self-Determination and Education Assistance Act (Public Law 93–638) to provide a program of instruction regarding alcohol and drug abuse to students in kindergarten and grades one through twelve. Schools providing programs of instruction under this subsection are encouraged to emphasize family participation in the programs.

(e) For the purpose of implementing subsection (b) there is authorized to be appropriated $1,500,000 for each of the fiscal years 1986, 1987, 1988, and 1989.

SEC. 4. (a) Any training program for community health representatives funded under the Act of November 2, 1921 (25 U.S.C. 13) shall include training on the problems of alcohol and drug abuse and shall include instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome.

(b)(1) The Secretary, in consultation with the Secretary of the Interior, shall either directly or through contract, make available training on the problems of alcohol and drug abuse, including instruction in crisis intervention, family relations, and the causes and effects of fetal alcohol syndrome to—

(A) the Bureau of Indian Affairs Superintendent of Education (or his designee);

(B) the Bureau of Indian Affairs Agency Superintendent (or his designees);

(C) Indian Health Service service unit directors;

(D) Bureau of Indian Affairs social workers;

(E) Indian Health Service doctors, nurses, nurse's aides, and paramedical personnel;

(F) Bureau of Indian Affairs school personnel;

(G) personnel of schools operated under contract under the Indian Self-Determination and Education Assistance Act (Public Law 93–638).

(2) The Secretary shall also make available, upon request, the training described in paragraph (1) to—

(A) Federally recognized tribal organizations and personnel, including but not limited to tribal council members, tribal court judges, and tribal law enforcement officials.

(B) Administrators of the Women, Infants and Children Program (WIC), operated by the Department of Agriculture; and

(C) Personnel of public schools on or near Indian reservations and public schools in Oklahoma, Alaska, and other States with significant numbers of Indian students;

(c) The Secretary shall, upon request, provide certification to any person who completes training under this section, for the purpose of obtaining academic credit or certification at any post-secondary educational institution.

SEC. 5. The Secretary shall, within one year of the date of enactment of this Act, conduct a study to determine—

(1) the size of the juvenile Indian population in need of residential alcohol and drug abuse treatment;

(2) the definition of a "crisis area" in which the need for treatment is critical and immediate;

(3) where other programs for emergency and long-term treatment should be located; and

(4) the cost of providing such treatment.

SEC. 6. The Secretary is authorized to enter into an agreement for the operation of any program authorized under this Act, with a "participating" tribe or tribal organization. A participating tribe or tribal organization is one that has notified the Secretary of its willingness to operate a program and to provide 25 per centum of the costs of such a program, either through funding, facilities, or in-kind services.

SEC. 7. There is authorized to be appropriated such sums as the Secretary and Congress determine to be necessary to carry out the provisions of this Act.

○

BACKGROUND ON H.R. 1156 & H.R. 2624

H.R. 1156 and H.R. 2624 provides for the development of a comprehensive effort to combat the severe, adverse impacts of alcohol and drug abuse among Indian youth. The Secretary of the Interior and the Secretary of Health and Human Services, acting through the Bureau of Indian Affairs and the Indian Health Service respectively, are directed to identify and coordinate existing efforts and resources to develop a comprehensive program of education, prevention, and treatment of alcoholism and drug abuse among juvenile Indians.

Alcohol (and more recently, drug) use and abuse is reportedly the most widespread, severe and all-encompassing health and social problem among American Indians today. Nothing is more costly to the Indian people than the consequences of alcohol and drug abuse whether measured in physical, mental, social or economic terms for the individual, the family, the community, or the entire population of Indian people.

The adverse impact of alcohol and the Indian concern is not new. In pre-colonial America, liquor became a bargaining tool for the white settlers who found it useful in negotiating treaties and trading rights with Indians. Traders found that alcohol led some Indians to give up their most valuable rights and alcoholic beverages became common in many Indian villages along the frontier.

Indian leaders of the time recognized the danger that alcohol use and abuse posed for their people and pleaded with the European and American governments to ban or restrict the use of alcohol by White traders.

As early as the 1820 treaty with the Choctaw, a provision of a treaty was included relating to the use of alcohol. Article 12 of that treaty stated:

> "In order to promote industry and sobriety amongst all classes of the Red people, in this nation, but particularly the poor, it is further provided by the parties, that the agent appointed to reside here, shall be, and he is hereby, vested with full power to seize and confiscate all the whiskey which may be introduced into said nation. . . ."

By the 1850's, such treaty provision, in many cases at the insistence of the Indians, became commonplace. For instance, article 7 of the 1854 Chippewa treaty stated:

> "No spirituous liquors shall be made, sold, or used on any of the lands herein set apart for the residence of the Indians, and the sale of the same shall be prohibited in the Territory hereby ceded, until otherwise ordered by the President."

Ironically, however, alcohol use was not practiced extensively by the Indian tribes before the influx of immigrant Europeans. Only tribes in Mexico and the American Southwest were known to have used alcoholic beverages and did so only as a part of ceremonial practice. The Papago, for instance, made a fermented liquor from the fruit of the giant cactus that was the central feature of one of their religious ceremonies. They drank only once a year.

In recognition of the severe, deleterious impact of alcohol upon the Indian tribes, Congress passed legislation, in 1832, prohibiting the sale of liquor to and among Indians. This law, supplemented by later amendments, became known as the "Indian

Prohibition Laws" and continued to effect until 1953, 20 years after the repeal of Prohibition Amendment to the Constitution.

Notwithstanding the legal attempts to ban or restrict the use of alcohol by Indian people, its use has become rampant in Indian communities. The 1985 Indian Health Service Chart Series shows that the age-adjusted alcoholism death rate per 100,000 population for Indian in 1982 was 35.8 as compared with a national rate of 6.4. This mortality rate includes deaths due to alcohol dependence syndrome, alcoholic psychoses, and chronic liver disease and cirrhosis. However, this simple statistic cannot adequately convey the disastrous social, cultural, and economic impacts of alcohol and drug abuse on Indian people.

Because of the nature and demography of Indian communities, the problem of Indian alcohol and drug abuse is most critical for the young. The 1980 census shows that the Indian population on Indian reservations is younger than the national population. 32% of the Indian population is younger than 15 years and 5% is over the age of 64. The corresponding figures for the Nation are 23% and 11% respectively. The Indian median age is 22.6 as compared with 30.0 for the Nation. The Indian birthrate of 27.9 per 100,000 population is 75% greater than the national birthrate of 15.8.

Considering only the health impact of alcohol and drug abuse, the impact on Indian youth is devastating. Deaths attributable to motor vehicle accidents, homicide, suicide, and alcoholism are reliable measures of the incidence of alcohol and drug abuse among Indian youth. The following statistics compare the Indian death rate per 100,000 population from these causes with the national rate for ages 5-14 and 15-24:

	Indians and Alaska Natives			U.S. All Races		
	Both Sexes	Male	Female	Both Sexes	Male	Female
			ACCIDENTS, MOTOR VEHICLE			
5-14 years		11.3	8.9		9.7	5.2
15-24 years		121.0	48.1		52.2	19.8
			SUICIDE			
5-14 years	0.7	1.2	0.2	0.5	0.7	0.3
15-24 years	28.0	48.6	9.0	12.3	19.7	4.6
			HOMICIDE			
5-14 years	1.4	1.9	1.0	1.3	1.4	1.2
15-24 years	22.4	35.2	9.5	14.7	23.0	6.2
			ALCOHOLISM			
5-14 years	---	---	---	---	---	---
15-24 years	3.2	4.9	1.6	0.2	0.2	0.1

A 1980-82 survey of drug use among Indian students of the Oglala Sioux on the Pine Ridge Reservation in South Dakota discloses the following comparisons:

Percentage of Students Having
Ever Used Drugs -- 1982

	Pine Ridge Total (12-17 year olds)	National Sample (12-17 year olds)
Alcohol	79.3%	65.3%
Marijuana	71.4	27.3
Inhalants (excluding Cocaine)	59.4	49.9
Stimulants	24.6	6.5
Tranquilizers	3.1	4.8
Sedatives	6.2	6.1
Cocaine	5.7	6.9
Hallucinogens	5.3	5.2
PCP	3.5	(not available)
Heroin	1.7	0.5

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Arrests made of juveniles for alcohol or drug related offenses is also a reliable measure of alcohol or drug use. The Division of Law Enforcement Services of the Bureau of Indian Affairs (Aberdeen Area Office) compiled statistics relating to the arrest of Indians under the age of 18 for alcohol/drug related misdemeanor offenses for period 1/1/83 to 12/31/83. The total of such arrests of Indian juveniles for that 3-State region alone is 840 with 103 being age 10 or under and 237 being age 17. The largest category of offenses are simple drunkeness. Of 160 male Indian juveniles arrested for drunkeness, 46 were 10 or younger and 59 were age 17. Of the 73 females, 9 were 10 or younger and 33 were age 17.

Despite the long existence of this severe problem on Indian reservations and the enormity of the problem, the Federal government, which has primary responsiblity, has done little to deal with its effects. The Indian Health Service in the Department of Health and Human Services, which has been statutorily charged with treatment and rehabilitation efforts has a small budget for this purpose. For FY1985, IHS was appropriated $24,482,000 for the alcoholism program. The primary focus of the IHS efforts is in the treatment of adult alcoholism and little of their effort is directed toward the problems of juvenile alcohol and drug abuse.

The Bureau of Indian Affairs in the Department of the Interior has developed and has responsiblity for programs in the field of education, social services, welfare services, child welfare, law enforcement, employment assistance, and economic development has assumed no responsibility for coordinating their various efforts to focus on the problems of juvenile alcoholism and drug abuse and very little, if any, of their funds are directed to that end.

SECTION-BY-SECTION ANALYSIS ON H.R. 1156

Section 1

Section 1 cites the Act as the "Indian Juvenile Alcohol and Drug Abuse Act".

TITLE I

Section 101

Subsection (a) provides that, within 90 days of enactment, the Secretary of the Interior and the Secretary of Health and Human Services enter into a memorandum of agreement to coordinate and delineate the programs and responsibilities of the two Departments in the field of Indian juvenile alcohol and drug abuse and to otherwise develop efforts to combat alcohol and drug abuse among Indian youth.

Subsection (b) provides that the two Secretaries shall consult with Indians in developing such an agreement and shall publish the agreement in the Federal Register.

Section 102

Section 102 provides that the two Secretaries, acting through the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS), shall bear equal responsiblity in implementing the provisions of the Act.

TITLE II

Section 201

Section 201 amends section 304 of the Indian Elementary and Secondary School Assistance Act to add a provision requiring the training of counselors in eligible schools in counseling techniques relevant to alcohol and drug abuse.

Section 202

Section 202 amends section 423 of the Indian Education Act to add a new subsection (e) to authorize the award of fellowship grants to persons receiving training in alcohol and drug abuse counseling.

Section 203

Section 203 amends section 315 of the Adult Education Act by adding a provision to provide alcohol and drug abuse services to Indians to aid them in taking advantage of educational and employment opportunities.

Section 204

Subsection (a) requires the Secretary of the Interior to insure that a program of instruction in alcohol and drug abuse is made available in BIA schools and schools operated under contract under the Indian Self-Determination Act (638) in kindergarten through grade twelve.

Subsection (b) provides that schools cited in subsection (a) are encouraged to emphasize family counseling in alcohol and drug abuse instruction.

Section 205

Subsection (a) directs the Secretary of the Interior to (1) establish summer recreation and employment programs of Indian youth on reservations; (2) keep BIA and 638 school facilities open during the summer months to facilitate such programs; and (3) provide salaried coordinators of such programs.

Subsection (b) encourages the Secretary of the Interior to use other available facilities, public and private, for summer programs under such terms and conditions as may be agreed to by the entity having jurisdiction over such facilities.

Subsection (c) directs the Secretary of the Interior to coordinate summer programs under this section with other available summer programs for Indian youth.

Section 206

Section 206 authorizes the Secretary of the Interior, in cooperation with the Secretary of HHS, to periodically publish an alcohol and drug abuse newsletter and to circulate such newsletter, without charge, to relevant public and private agencies providing alcohol and drug abuse services to Indian people.

TITLE III

Section 301

Subsection (a) provides that any training program for Community Health Representative (CHR's) shall include not less than two weeks on alcohol and drug abuse including crisis intervention, family relations, and fetal alcohol syndrome.

Subsection (b) directs the Director of IHS to make similar training available to various BIA and IHS personnel, school personnel of under 638 contracts, and emergency shelter supervisors under section 402 of this bill. In addition, upon request, the Director is to make such training available to various school boards of schools serving Indian children and numerous other persons working in the field of Indian affairs.

Subsection (c) provides that the Secretary of HHS will, upon request, provide certification to persons trained under this title for purposes of scholastic credit.

TITLE IV

Section 401

Section 401 provides that the head of the BIA shall provide alcohol and drug abuse training to BIA law enforcement personnel.

Section 402

Subsection (a) provides that any tribal, Federal, or BIA law enforcement personnel arresting an Indian juvenile for an offense relating to alcohol or drug abuse shall place such juvenile in an emergency shelter as described in subsection (c) or in a community based alcohol or drug treatment facility in lieu of incarceration. Nothing in the subsection is to supercede any tribal law. In addition, it provides that the Secretary of the Interior in consultation with the Attorney General can develop guidelines for the incarceration of an Indian juvenile arrested for alcohol and drug related offenses in facilities other than emergency shelters.

Subsection (b) provides that any State which exercises criminal jurisdiction within Indian country pursuant to Public Law 280 shall be urged to comply with the provisions of subsection (a).

Subsection (c) directs the BIA to establish a program and a compensation schedule for the use of Indian homes as temporary emergency shelters for Indian juveniles arrested for alcohol or drug related offenses. No such emergency shelter is to be established or commence operation without tribal approval or without meeting the licensing requirement which the BIA is to establish. Standards developed for BIA for such licensing is to require that individuals have completed training described in section 301 of the bill.

TITLE V

Section 501

Section 501 directs IHS to conduct a study to determine the number of juvenile Indians needing residential alcohol and drug treatment, where such facilities should be located, and the cost of providing such treatment.

Section 502

Subsection (a) directs IHS to provide comprehensive alcohol and drug abuse treatment, including de-tox, counseling, and follow-up care, in IHS facilities or facilities operated under 638 contracts.

Subsection (b) provides that no such facility shall be required to provide inpatient care if the facility is primarily an outpatient facility.

Subsection (c) requires IHS to make a report to Congress on progress under this section 18 months after completion of the study required by section 501.

Section 503

Subsection (a) directs the Secretary of HHS, in consultation with IHS and BIA to identify and, wherever possible, utilize existing Federal facilities for residential treatment centers to meet needs identified in the section 501 study. These facilities may be used under any terms or conditions agreed to by the Secretary and the agency having jurisdiction over such facilities. The Secretary is authorized to renovate such facilites under the terms and conditions agreed to between the Secretary and the relevant agency.

Subsection (b) provides that the Secretary of the Interior is to identify, for the Secretary of HHS any existing BIA facilities which could be used as residential treatment centers.

Subsection (c) provides that, if there is not an adequate number of facilities which may be renovated under subsection (a)(3) to meet the needs identified in the section 501 study, the Secretary of HHS shall seek specific authority to construct such facilities as he finds necessary.

TITLE VI

Section 601

Section 601 defines the terms "Indian tribe", "Indian", "juvenile", "service unit", "service area", "Indian Health Service area office", "Bureau of Indian Affairs area office" and "agency office".

Section 602

Section 602 provides that title I and VI and section 402(b)(3) shall become effective upon enactment.

Section 603

Subsection (a) provides that there are authorized to be appropriated $5,000,000 to carry out the provisions of titles III and IV and section 501.

Subsection (b) authorizes the appropriation of such sums as may be necessary to carry out section 502 and 503 based upon the findings of the study under section 501.

SECTION BY SECTION ANALYSIS

H.R. 2624, a bill "To authorize programs for the treatment and prevention of drug and alcohol abuse among Indian juvenile".

FIRST SECTION

This section authorizes and directs the Secretary of Health and Human Services to formulate, within existing programs, a Indian Juvenile Treatment Program. The Secretary is also authorized to reallocate existing funds and personnel to "crisis areas", determined in section 5.

SECTION 2

This section directs the Secretary to establish a departmental coordinating office for the Indian Juvenile Treatment Program within the Alcohol, Drug Abuse and Mental Health Administration. The Secretary is also directed to consult with the tribes on implementing programs pursuant to the Act.

SECTION 3

This section authorizes an appropriate agreement between the Secretaries of HHS, of the Interior and of Education to coordinate efforts among the Department to treat and prevent Indian juvenile drug and alcohol abuse. The section also authorizes a training program in prevention and counseling of drug and alcohol abuse, and authorize $1.5 million annually for fiscal years 1986-1989 for the program. This section also mandates that Bureau of Indian Affairs(DOI) operated schools and contract schools (P.L.93-638) provide programs for K-12, encouraging family participation.

SECTION 4

This section provides that the training of community health representatives funded under the Synder Act include problems of drug and alcohol abuse, crisis intervention, family relations and fetal alcohol syndrome.

This section also mandates that such training be made available to a list of personnel and officials associated with Indian affairs.

SECTION 5

This section authorizes a study of the extent of the problem, a definition of a "crisis area", the location of emergency and long-term treatment, and associated costs.

SECTION 6

This section authorizes the operation of these programs by participating tribes -- tribes that agree to provide 25% of the costs, through funding, facilities or in-kind services.

SECTION 7

This section authorizes appropriations for programs established.

Mr. Moody. The committee has held 3 days of field hearings on this legislation in South Dakota, New Mexico, and Arizona. In addition, we are working closely with the Senate Select Committee on Indian Affairs which has also held several hearings on this legislation. So we have a very extensive record.

Today, with administration and other testimony, we will complete our hearings and begin the process of moving a bill out of the committee and onto the floor.

To quote the statement of the administration which will be presented to this committee today, this is "the most serious social and health problem facing Indian people today."

I will turn the gavel over to our Honorable chairman, Mr. Udall.

The Chairman I apologize for being late. I assured the staff that you should go ahead, you and Mr. McCain.

Mr. McCain. Mr. Chairman, I would like to make a statement.

Mr. Moody. Of course. Go ahead.

Mr. McCain. Mr. Chairman, I would like to submit a statement in full for the record, if I may, and just briefly summarize my remarks.

Mr. Moody. Without objection.

[Editor's note.—Prepared statement of Hon. John McCain may be found in appendix I.]

Mr. McCain. First of all, I would like to express my appreciation to both Mr. Daschle and Mr. Bereuter for their dedication to trying to assist in alleviating probably one of the most severe issues that faces our Indian reservations. I would particularly like to express my appreciation to Mr. Bereuter who preceded me as the Chairman of the Republican Task Force on Indian Affairs. Mr. Bereuter attacked that task with dedication and set a very high standard for me to try and live up to when he left the committee.

Mr. Chairman, I do not want to waste the committee's time by emphasizing the tragedy that continues to unfold on a daily basis on Indian reservations throughout America. I would like, if I may, to quote a letter that I received from Mr. Norman Austin, who is the Council President of the Fort McDowell Mohave Apache Indian Community in Fountain Hills, Arizona. It says:

> Dear Mr. Chairman: I am aware that H.R. 2624, introduced by you, and H.R. 1156, introduced by Congressman Bereuter, are bills that would directly address the problems of juvenile alcohol and drug abuse on Indian reservations. In the Fort McDowell Mohave Apache Indian Community 65 percent of our juveniles are abusing alcohol or other drugs. Our young people are an important human resource to us since half the reservation population is made up of people under 25 years of age.

I would just like to repeat that. Sixty-five percent of the juveniles on that reservation are abusing alcohol or other drugs; over half the reservation population is made up of people under 25 years of age. This is not an unusual example. In fact, it is very typical of the situation that exists on reservations throughout America.

I will be looking forward very much to hearing the testimony of the witnesses today. I know from seeing copies of their testimony that to some degree both the representatives of IHS and BIA feel that significant steps are being taken. My question to them will be, what are the results? I think the answer may be that there are more steps that need to be taken. There is not any evidence that I have seen of improvement in this problem. That is why I think Mr.

Bereuter and Mr. Daschle's bill is very important for consideration, as well as my own.

Finally, I would just like to say one more thing about both bills. I think any bill that we pass out of this committee must be considered as to its opportunity of final passage and receiving administration support. The great debate is now taking place in the Congress of the United States on Gramm-Rudman, which will entail further budget cuts; it will require difficult decisions to be made. I think that we ought to address a bill which has the best opportunity for passage and administration support.

I look forward to working with Mr. Daschle and Mr. Bereuter in shaping that kind of legislation.

Thank you, Mr. Chairman.

Mr. **Moody**. Thank you.

The **Chairman**. Would the chairman recognize me for just a moment.

Mr. **Moody**. The gentleman from Arizona.

The **Chairman**. I have about four hearings I am supposed to be at this morning and I don't want to miss anything here if I can help it, because this has been something I have been concerned with with my colleagues Mr. Bereuter and Mr. Daschle and a number of others.

I remember being out in New Mexico a couple of years ago and talking about Indian problems generally. We asked local leaders of the Navajo community if they had to name one problem, what would it be? It was the alcohol and drug abuse problem that most of them identified.

We have not done very much these last 2 years and I take part of the blame. One of my hopes is that in this Congress we can take some steps to begin to grapple with this very difficult social and family problem that affects our Indian brothers and sisters more than perhaps anyone else.

So I will be in and out of here this morning. I hope Mr. Moody can help preside. But I wanted to emphasize the importance I place on this issue and my determination to do something about it this time around.

Mr. Chairman, I particularly want to thank Mr. McCain. I omitted to mention him. He has done as much or more than anybody else on this committee to keep pushing this issue along. Without him we would not be where we are. I appreciate his support and help and advice very much.

Mr. **Moody**. Very good. Thank you.

Our first witnesses are the Honorable Thomas A. Daschle and the Honorable Douglas K. Bereuter.

[Prepared statement of Hon. Thomas A. Daschle may be found in appendix I.]

STATEMENT OF HON. THOMAS A. DASCHLE, A U.S. REPRESENTATIVE FROM THE STATE OF SOUTH DAKOTA

Mr. **Daschle**. Mr. Chairman, I want to add my thanks to Mr. McCain and to our chairman of the full committee, Mr. Udall, for their diligent effort, their oversight and their demonstrated concern about what Mr. McCain so eloquently stated to be perhaps the single most important problem facing the Indian community when health considerations are taken into account.

Mr. Chairman, we are grateful to you also for this opportunity. I have a statement that I would like to present at this time.

Alcohol and drug abuse among native Americans, especially among Indian youth, remains a devastating and debilitating problem on reservations in my home state of South Dakota as well as across the country.

Without question, alcoholism and drug abuse is the number one social and health problem among native Americans. The 1980 Census shows that alcoholism for Indians is 451 percent higher than the rest of the U.S. population. Alcohol related death and disease are the biggest killers on the reservation, nearly eight times greater than that of the non-Indian community. The impact of substance abuse in the Indian community is revealed in statistics directly related to trouble with the law, a high rate of suicide, and disruption of family life.

These troubles have unfortunately but unquestionably been passed along to the younger generation of native Americans. Indian children are drinking alcohol frequently by the age of 13, studies show, and the use of marijuana and inhalants like Lysol, paint thinner, antifreeze, and other toxic substances is beginning at a very earlier age and occurring more often. One study that came out in our South Dakota hearing, which I think is incredible, indicated that among 4th, 5th and 6th graders on the Pine Ridge Reservation as many as 35 percent of elementary school children have experimented with or continue to use alcohol.

We can no longer deny that a crisis exists. Furthermore, we can no longer afford to sit back and hope that this problem will solve itself. It has not done so in the past and it simply will not resolve itself in the future.

That is why Congressman Bereuter and I are here today, to continue to plead the case for the Indian Juvenile Alcohol and Drug Abuse Prevention Act. We saw a need for this legislation 2 years ago. In 1983 we began to develop legislation which would focus not just on the causes of the Indian youth substance abuse problem but would also provide educational programs about its dangers and identify the problem cases and establish counseling and treatment programs as well.

The Indian alcohol bill is an improved version of the legislation that Congressman Bereuter and I introduced in the 98th Congress. We know that it needs additional work, additional attention, additional oversight on the part of this committee. We are clearly of the mind that we certainly need to develop this legislation this year, that we need to continue to work and in the process come up with a bill that we can support in a strong bipartisan effort.

Throughout the development of this measure we consulted over 700 Indian leaders and health professionals, both groups and individuals, in order to receive their suggestions and valuable insight. The legislation that is being discussed in the Interior Committee today reflects information and ideas gathered from and presented by a wide range of authoritative sources, from agencies here in

Washington to local tribal members who have personally witnessed the tragedies caused by alcohol and drug abuse on the reservation.

There has been bipartisan support in the House for legislation such as this since it was originally introduced, and that strong support is evident on both sides of the aisle today. A companion bill is being considered in the Senate and also enjoys bipartisan support. Because an issue like this, a desperately needed attempt to improve lives, to save lives, supersedes any political concerns.

Numerous hearings have been held across the country in the past two years on the Indian juvenile alcohol bill, and it is unanimously acknowledged that we must act on it now before yet another generation of native Americans is ravaged by this problem.

Congressional action is essential because of the current Administration's lack of attention and effort toward the Indian juvenile substance abuse problem. While officials of the Bureau of Indian Affairs and the Indian Health Service admit that alcohol and drug abuse is the most serious social and health problem facing Indian people, the IHS has directed only one percent of its budget toward the combined area of drug and alcohol abuse. Such a lack of resouces, a lack of response, a lack of initiative applied to the drug and alcohol problem clearly proves it is not a priority. But I would emphasize here that it has not been a priority in past Administrations either or we would not have the problem that we have today.

They claim that sufficient funding and adequate programs are already in place to deal with alcohol and drug abuse. I believe that such claims are unfounded and that they present an attitude of insensitivity and apathy on the part of the bureaucracy toward the needs that really exist at the local level. BIA and contract schools on most reservations are lacking in comprehensive, or even minimal, programs to address the abuse problem.

The schools are also our greatest hope for attacking the problem. A preventive approach is the underlying premise of the Indian juvenile alcohol bill, which provides training for teachers as well as educational and instructional programs and other structured activities for students. If we can reach Indian students at an early age and make them aware of the dangers of substance abuse, we have an important opportunity to prevent their involvement with the problems I mentioned earlier in my testimony.

I hear repeated complaints of an absence of coordination between the Bureau of Indian Affairs and the Indian Health Service, and I understand that there are seldom any attempts on their part to involve local tribal governments in policy and program decisions in this regard. Other reports I have received from Indian leaders in South Dakota indicate that there is a serious lack of quality evaluation, monitoring and direction in the few programs which do presently exist. Title I of the Indian juvenile alcohol bill would require the BIA and IHS to coordinate their efforts and resources and to periodically review their joint progress.

One of these few successful programs is Project Phoenix, a residential treatment center for native American youth located on the Pine Ridge Indian Reservation. It is operated on a contract basis with the Indian Health Service.

While Project Phoenix has made a significant contribution in the past 5 years in helping hundreds of young Indian people salvage their lives from the danger of serious alcohol and drug abuse problems, there are thousands more who still need help. Each month the project must turn away dozens of potential clients because of a lack of space and unsafe facilities. IHS training programs are infrequent and can create financial, transportation, and scheduling difficulties for counselors. Project Phoenix has a number of problems and needs that must be addressed. Certainly this bill will help in that regard. Title V of the Indian juvenile alcohol bill would ease these problems by directing the BIA and IHS to study thoroughly the extent of the drug and alcohol problem and would provide treatment services such as detoxification, counseling, and followup care.

The Indian Juvenile Alcohol and Drug Abuse Prevention Act would not only supplement and strengthen Project Phoenix, but it would improve the relatively few existing services and develop new preventive and educational programs in the schools. These changes and additions are desperately needed by the Indian population. I strongly urge the members of the Committee to act swiftly and judiciously to report this bill or something similar for consideration by the full House.

I thank the members of the committee for their attention this morning and certainly their support for this effort.

Mr. MOODY. Thank you.

Mr. Bereuter.

STATEMENT OF HON. DOUGLAS K. BEREUTER, A U.S. REPRESENTATIVE FROM THE STATE OF NEBRASKA

Mr. BEREUTER. Thank you, Mr. Chairman, and Chairman Udall.

Mr. McCain, I want to say that I have always felt very good about having you follow me in that responsibility for people on our side of the aisle. You have been extremely dedicated and competent in pursuing it, and I feel very good about the leadership you have brought to the subject. And I appreciate your kind words as well.

It is always a pleasure to testify before this committee. My only disappointment is that it is not in the main hearing room, because that is one of my favorite places in the whole Capitol Hill area.

Today I am here to talk about a matter that is extremely important to me as well as to hundreds of thousands of young Indian children growing up in a difficult and challenging world. I am here to talk about the pervasive problem of alcohol and drug dependency that occurs far too much on reservations and in Indian communities across the United States.

For several decades researchers have been investigating the use and consequences of alcohol and drug abuse among native Americans. Inevitably stereotypes developed about Indian drinking patterns, although it is important to note that the phenomenon began with the introduction of alcohol by early European explorers. Not only did they bring horses, guns, and tools for trading purposes, but they brought whiskey as well.

While clearly the reasons leading to such high rates of alcohol and drug abuse among Indian people are complex, most Indian and non-Indian researchers alike point to joblessness, dislocation from tribal homelands, a decline in the importance of traditional cultural and religious influences, and increased external stresses on the family unit as being among the major causes of alcohol and drug abuse.

Obviously something needed to be done. This need goes back a long, long way. I think we ought to expect that the blame not be specifically directed to any one group of people, any one President, any one Administration, and that the natural bureaucratic tendency of any institution to be defensive ought to be resisted. We ought to all move forward and try to find a solution and implement it.

As a result of concern that Mr. Daschle and I shared, in November 1983 we began discussing the extensive problems of alcohol and drug abuse that we had observed among Indian youth on reservations in our own states and across the nation. Working closely with the Interior Committee staff and members of the Interior Committee, we drafted a bill that we introduced late in the 98th Congress as a discussion draft, H.R. 6196, the Indian Juvenile Alcohol and Drug Abuse Prevention Act. We then mailed this legislation for discussion to some 700 Indian tribal leaders, health and education specialists and policymakers throughout the United States, soliciting their suggestions and opinions.

As a result of the hundreds of responses we received we redrafted the measure and reintroduced it in this Congress, where it is known as H.R. 1156.

In this regard, I would take this opportunity to express on the record my tremendous appreciation for all the comments, the tribal resolutions of support, and helpful suggestions that we received from Indian people from all corners of Indian country and urban areas, from Alaska to the Carolinas. Without their very concrete assistance we could not have produced the legislation that you are hearing today.

I might mention at this point that we have 57 cosponsors, a bipartisan basis for H.R. 1156. I also want to say that I am pleased to be an original cosponsor of the legislation introduced by John McCain, H.R. 2624. We are looking for, as Mr. McCain put it, the bill that will be passed, signed into law and implemented.

The great response from Indian people was not really a surprise. After all, tribal leaders have been telling Congress for some time that alcohol and drug abuse is one of the greatest and perhaps the greatest health and social problem found on reservations today.

Recognizing the urgency of the problem, members of the Senate were also stimulated to offer legislation. Senator Mark Andrews of North Dakota and a bipartisan group of cosponsors introduced companion legislation and have held one hearing in this city. That bill, incidentally, is almost exactly like the one that you are hearing here today. Tomorrow they are conducting their final hearing in Anchorage, Alaska. My sincere thanks to my Senate counterparts too for their swift response.

Finally, I want to say a word of thanks to the Bureau of Indian Affairs and Indian Health Service for their actions in response to congressional interest. While, candidly, we do not believe that their actions go far enough nor that they are sufficiently comprehensive, we have known and can see that they too share our concerns and the concerns of the Indian people everywhere. We certainly agree that the insidious and devastating hold of alcohol and drugs on Indian young people must be stopped.

Now I want to turn to a few points of substance in my testimony today about the bill. Naturally I believe that all the provisions of this bill are important, but today I will focus on only a couple.

The first matter I will address is what we mean as cosponsors of this legislation by the term "program of instruction," a term used in section 204 on page 5 of the bill. I think this is crucial, because you are going to be receiving testimony following this explaining the existing educational prevention efforts.

The bill would require the Bureau of Indian Affairs schools and Bureau contract schools to offer programs of instruction in alcohol and drug abuse prevention from kindergarten through 12th grades. The legislation would encourage public schools that serve Indian children to do the same. The point here is that we want alcohol and drug abuse prevention and education to be a regular, consistent part of the academic program, interwoven where appropriate into health and physical education programs or history programs or science or creative writing classes. The limits of teachers' imaginations are the only limits to the ways that prevention can be taught. Moreover, I specifically reject a 1-hour audio-visual presentation, for example, an occasional evening lecture for families and young people, or information posted on the school bulletin board as meeting the definitions or intent I have in using the phrase "program of instruction."

I do not mean to suggest that this kind of minor emphasis given to this serious problem is typical, but I want to be very specific and say what we have in mind in this. Neither do I believe it is acceptable to have critical drug and alcohol prevention programs subject to the vagaries of yearly funding competition or the shifting priorities of administrators or teachers. We have heard too many stories of tribes with drug and alcohol prevention programs well underway who lose funding in subsequent years. Providing this critical type of integrated educational offering in the classroom setting is the best way to guard against the uneven funding patterns of competing projects or emphases.

There is another education related matter that I wish to discuss, Mr. Chairman. Our bill, H.R. 1156, makes provision to reach Indian young children in public schools by expanding the Indian Education Act, Title IV. I believe that is perhaps lacking in the Senate version.

I believe that meeting drug and alcohol prevention needs for Indian youth would be incomplete if urban Indian adolescents were not included in our efforts or concerns. After all, 50 percent of Indian people now live in urban areas. In addition, there are some areas where nearly all Indian children on a reservation attend public schools. This is the case in my congressional district, the First District of Nebraska. Nearly all of the children of the Santee Sioux, the Omaha, and the Winnebago tribes of Nebraska are served by public schools.

I would be disappointed if my effort to combat alcohol and drug abuse among Indian youth did not benefit my own constituents. Thus we revised Part A of the Indian Education Act to include as eligible activities alcohol and drug abuse counseling. We also specified that Part C moneys would be made available to urban Indian centers for the training of alcohol and drug abuse counselors. And we set aside 10 percent of Part B moneys for graduate fellowships, although that is a matter of some controversy. But I think it is the only way we are effectively going to see sufficient moneys going to training counselors in this area.

When the use of Title IV provisions, which fund culturally relevant programs under the Indian Education Act, are inadequate to help Indian children in the public school setting, Part C moneys that can be used to train counselors in Indian centers become particularly important. Experts have advised us that oftentimes the Indian center provides a more secure, culturally relevant setting for such young people. Therefore the role of Indian centers in urban areas in this effort is a crucial one. They and the public schools will provide the necessary and vital leadership needed in urban Indian communities in the fight against alcohol and drug abuse.

Finally, Mr. Chairman and members of the subcommittee, I want to share with the subcommittee an experience I had at a public school on one of the reservations in my district. The impact of that visit some 2 or 3 years ago has provided me with a constant source of deep concern and resultant commitment to this legislation. Some time ago I spent an afternoon at a school that has a fetal alcohol syndrome program run by the Carl T. Curtis Health Education Center in conjunction with the Omaha Tribe. Fetal alcohol syndrome, as most of my colleagues know, is caused by excessive drinking during pregnancy. The most common manifestations of the syndrome are varying degrees of mental retardation, facial abnormalities and abnormalities to the extremities, reduced birth weight and length, as well as lifelong growth deficiencies. Fetal alcohol effect is a less devastating result of maternal drinking.

The tragic consequences of fetal alcohol syndrome and the ensuing terrible waste of human lives can be totally prevented if mothers abstain from alcohol consumption during pregnancy. But without prenatal counseling about the effects of alcohol on the growth and development of the fetus many young mothers will never know what their drinking is doing to their unborn babies.

If you were to see the proportion of Indian children that are suffering from mental retardation as a direct result of fetal alcohol syndrome in these schools, I think most of you, despite your knowledge of Indian affairs, would be shocked and appalled. Certainly our colleagues who never get to an Indian reservation would be appalled.

There is nothing more precious than the health and well-being of a community's youth. As I am sure all of you would agree, young people who have their health, their pride and sense of self-worth will grow up to make the changes and meet the challenges that are necessary to any society's growth and survival. I suggest that the existence of strong, culturally viable, proud and self-sufficient American Indian communities within our midst enriches the lives of all Americans and reaffirms our dedication to a pluralistic society. I firmly believe that this legislation is a necessary component in the effort to achieve that goal.

In closing, Mr. Chairman and members of the committee, I request permission to submit for the hearing record the letters of official comment that we have received regarding H.R. 6196 of the 98th Congress and now H.R. 1156. I believe that these letters will form an important addendum to the hearing record.

I thank you for your interest, your time and support, and we welcome any questions you might have for us.

Mr. **Moody**. Thank you very much. Without objection, those letters will be made part of the record.

[**Editor's note**.—At time of printing, Mr. Bereuter had not yet supplied the above-mentioned letters. When received, they will be placed in the committee files of today's hearing.]

Mr. **Moody**. Does the gentleman from Arizona have any questions?

The **Chairman**. No. I just want to commend my two colleagues for their ongoing support for this program. These are two very eloquent statements. I do not think I have very much to add to them.

I do think, as Mr. Bereuter pointed out, that we have got to insist upon a major ongoing adequate program. The Administration's testimony in few minutes will tell us that there are something like 122 programs in effect, which would seem to me to be suggesting daily ongoing programs. Actually they count a slide show once or twice a year as an ongoing program; they count things that are very small and really do not touch on a continuing basis the people on our Indian reservations. I hope we will focus on these things and this legislation will bring about a much better situation than we have today.

Thank you.

Mr. **Moody**. Thank you, Mr. Chairman.

The other gentleman from Arizona.

Mr. **McCain**. I would just like to thank my two colleagues for very important and impressive statements. I would like to elaborate on what the chairman said. The statements, which I have read, indicate that there are ongoing and serious programs. I do not deny those statements. What I do question, and I think the reason why there is need for legislation, is what has been the effect? I hope that the witnesses that are coming up can show us where there has been some improvement. So far the evidence that my two colleagues and I have been able to obtain shows that not only has there been no improvement, but there has been a serious regression. That is why I think there is a strong requirement for the Administration to consider further legislation.

Thank you very much, Mr. Chairman. I thank my colleagues.

Mr. **Moody**. Thank you.

Let me just ask a question myself. I know you are not here to testify on both bills, but could you just briefly outline the cost level of your bill and perhaps comment on the cost level of the other bill?

Mr. **Bereuter**. I will be happy to try. We have a specific authorization of $5 million to carry out Title II, III and IV, which relate to law enforcement, family and social services and education.

Mr. McCain's bill, unless I am misinformed, has an authorization of $1.5 million a year for education and training provisions. The rest of the training would be out of existing HHS authority.

I do think it is probably important to mention that the bill in the other body calls for such sums as are necessary.

It is also probably important to mention that while there was some early confusion section 503(c) does not authorize construction of facilities. So that is an important point I hope you will keep in mind. We asked that they look at existing Federal facilities and then after looking at that come up with a deficit of facilities that might be needed. But an additional separate authorization would be required. Section 503, we have been told, and, we certainly intended, does not constitute an authorization for construction.

Mr. DASCHLE. We think it is important that a dollar amount be affixed at this point. Clearly you can authorize additional amounts as you see the need, but I think some cost savings may actually be accrued as well through much better coordination between BIA and IHS and therefore a better understanding of what effort is underway currently in the 122 projects, many of which may cost more money but certainly have not demonstrated, as Mr. McCain said, the effectiveness that they must to show the successful effort in trying to address this problem.

Speaking for myself, I think it is difficult to affix a financial cost here. Budgetarily it may be more than $5 million, but I think that is an accurate assumption. It is a way to begin. I think that a dollar amount has to be associated with this program. To the best that we can establish, that is probably as reasonable an amount of money as one could anticipate going into the program for the first year.

Mr. BEREUTER. May I continue?

Mr. MOODY. Sure.

Mr. BEREUTER. We tried, of course, to be conservative in our amount. People may well ask, how can you really accomplish anything for an annual authorization of $5 million? Of course what is important to bear in mind is the fact that we are talking about two primary agencies in different cabinet level departments plus other Federal Agencies that have an impact. I think coordination of existing programs through required agreements, memos of understanding, are crucial. It can be argued these things can be done already, and indeed it is true most of them could be done. But they obviously have not been done effectively, and I think that legislation, statutory direction where we can measure the results and specifically identify the expectations that Congress has for the kind of coordination necessary to use existing facilities is essential, and that is why we are able to accomplish what we think are major improvements with only $5 million authorization included.

Mr. DASCHLE. I would say one other point. It is not only existing facilities but existing budget. I think there is room within the current budget. If we would address the goals that we have set out in this bill and try to address the organizational and structural response to those goals, not only can we use existing facilities but we can also use existing funds. Clearly in a year or so we may have to reevaluate total cost and the impact that this is having, but I have to say with some optimism that we can do this effectively given current budget constraints and setting out the appropriate goals with the budget and facilities that we have.

Mr. **Moody**. Are there any studies that either of you gentlemen are aware of—and perhaps other witnesses later on will bring them up—that have pointed out the financial and social costs of not attending to the problem? That is, it is not free to do nothing; there are very serious and expensive consequences of the current state of affairs. Has there been any quantification or measure of that?

Mr. **Daschle**. There have been efforts to quantify it, I do not think successfully. There are parochial studies that have been done, individual studies with regard to the impact on health care in particular. But when one looks at health care and unemployment, the problems that we have in trying to provide the means by which these people can even survive on the reservation, the economic impact is clearly very, very devastating. While there may not be a comprehensive report, there are plenty of reports on a specific basis dealing with specific reservations that give us pause and certainly give us a better understanding of the implications of having done nothing so far.

Mr. **Moody**. Is it your impression that the cost of the current situation would probably exceed many, many millions of dollars? It would sound that way. Do you have any indication that that is so?

Mr. **Daschle**. Based on the data that we have, there is no doubt about it. Given the studies and the hearings that have already been held in Arizona and South Dakota and elsewhere, the overwhelming evidence is that because the situation has now become so grave, not only among the adult population but also among the children, the cost of maintaining adequate health and economic stability on the reservation is dramatically increasing simply because we are not effectively dealing with this problem.

Mr. **Bereuter**. I have heard Indian leaders and people who are trained in the field suggest that over half of what we spend for assistance in the area of medical assistance and social service assistance to the Indian people of this country is directly related to Indian abuse of alcohol and drugs; over half of our total expenditures for medical and social service needs is related to that problem. I have no doubt that that is conservative.

Mr. **Daschle**. Ninety-one percent of the arrests—and I could be off by one or two percentage points—on reservations today are alcohol related.

Mr. **Moody**. Obviously all of those have costs.

Mr. Bereuter, do you know what the total cost is? You say over half is related to alcohol. Do you know what that total is? We can look it up.

Mr. **Bereuter**. Total medical costs? I do not know at this moment.

Mr. **Moody**. Probably a lot more than $5 million.

Mr. **Bereuter**. I think we are talking about hundreds of millions of dollars annually.

Mr. **Moody**. Probably close to $½ billion. To the extent that that could be impacted, this bill might be very cost effective.

Mr. **Daschle**. There is no questions about that.

Mr. **Bereuter**. That is right. All one has to do to get a quick idea of it is to go to an Indian Health Service hospital and see the extent of the hospital's resources that are set aside specifically for treatment of people with this difficulty.

Mr. MOODY. Are there any further comments?

[No response.]

Mr. MOODY. Thank you very much.

Our next witness is Mrs. Hazel Elbert, Acting Deputy Assistant Secretary for Indian Affairs, U.S. Department of the Interior.

[Prepared statement of Hon. Hazel Elbert, with attachment, may be found in appendix I.]

STATEMENT OF HON. HAZEL ELBERT, ACTING DEPUTY ASSISTANT SECRETARY FOR INDIAN AFFAIRS, U.S. DEPARTMENT OF THE INTERIOR, ACCOMPANIED BY NANCY C. GARRETT, DEPUTY DIRECTOR, OFFICE OF INDIAN EDUCATION PROGRAMS

Mrs. ELBERT. Good morning, Mr. Chairman and members of the Committee. I am pleased to be here today to discuss with the committee the views of the Department of the Interior on H.R. 1156 and H.R. 2624 which deal with the prevention, identification and treatment of alcohol and drug abuse among Indian youth.

Based on the testimony presented by the previous two witnesses and discussions that the committee has had this morning, it is obvious that everyone has read the Department's statement. If it is OK with the committee, I would like to submit the statement for the record and answer questions that you might have.

Mr. MOODY. Without objection, the full statement will be made a part of the record.

Mrs. ELBERT. I have with me to help answer questions on the education portion of the testimony Nancy Garrett, who is the Deputy Director, Office of Indian Education Programs, in the Bureau.

Mr. MOODY. Mrs. Elbert, would you take a moment just to summarize your statement to give us a point of departure?

Mrs. ELBERT. Mr. Chairman, we too consider alcohol and drug abuse to be the most serious social and health problem facing Indian people today. Our statistics show that the majority of BIA and tribal arrests involve alcohol and drug abuse and that many of those arrested are juveniles.

The two bills that we are discussing here today attempt to address the critical problem of alcohol and drug abuse in Indian country by requiring more coordination of information and services between the BIA and the Indian Health Service; training of all personnel working directly with Indian youth; a more comprehensive education program in BIA schools; alternative placements for children arrested for drug and alcohol related offenses; and more comprehensive alcohol and drug abuse treatment centers, which include detoxification facilities, counseling services, and followup care.

Mr. Chairman, while we support the concepts of the legislation, we oppose both of the bills as they are drafted. We agree there is a need for better coordination with the Indian Health Service, which H.R. 1156 provides. However, we believe that the Indian Health Service is in a better position to provide services available to people in the immediate geographic areas. We also question whether there is a need for formal tribe-by-tribe agreements to identify and coordinate services which would force assistance to be allotted on a first-come, first-served basis rather than to where the greatest need might exist.

Both of the bills require that alcohol and drug abuse instructional programs be provided to all students in BIA and contract schools. We believe that this provision would be an appropriate replacement for the Indian school provisions in the Act of May 29, 1886, which requires similar instruction.

We have 122 alcohol and drug abuse programs in place in our schools. We have attached a list of these schools to our testimony. This year we plan to expand and improve these programs, in connection with an interagency agreement with the Department of Justice under which we have received $150,000, for training school and dormitory staff in alcohol and drug abuse programs and for purchasing classroom materials. Our preliminary plans are to provide training to teachers from 48 schools in 8 locations. This program will also provide materials to schools which can be used immediately by the teachers after they receive the training. We estimate that this program will affect approximately 10,000 students.

In addition, five of our employees will receive training in Seattle and become trainers of a new in-house training cadre. This cadre will be used throughout the Bureau's education system to train other teachers and staff.

Title II of H.R. 1156 requires the BIA and contract schools to remain open during the summer months to provide recreation and counseling programs to Indian youth. We believe that this provision is unnecessary and would require the Bureau to provide programs that should be left to the Secretary's discretion. The need for such programs should be determined by the agency on the basis of need and availability of resources rather than by congressional mandate.

Finally, Title II of H.R. 1156 requires the Bureau to publish a quarterly newsletter to report on Indian alcohol and drug abuse projects. We feel that this provision is unnecessary. The Bureau recently contracted with the Tom Clary Institute Inc. to publish and distribute a newsletter called "Linkages for Indian Child Welfare Programs." We propose expanding this newsletter to include topics on juvenile alcoholism and drug abuse. The first issue is scheduled to be published under the contract this month, and I believe we already have that publication in the mail to the recipients of the newsletter.

Title IV of H.R. 1156 authorizes the Secretary of the Interior to promulgate guidelines authorizing law enforcement officers to place juveniles arrested for offenses related to the abuse of alcohol and drugs in emergency shelters or a community-based treatment facility. We agree that where such facilities are available law enforcement officers should have guidelines to asist them in determining proper placement of juveniles when they are apprehended.

Title IV of H.R. 1156 also requires the Secretary to establish temporary emergency shelters to house Indian juveniles apprehended for offenses relating to alcohol and drug abuse. We recognize the need for some kind of emergency shelter or facility to address the problem. However, we must assure that any facilities that we establish for these purposes are not duplicative of the existing networks of special care facilities and foster homes supported by the Indian Child Welfare Act grant program. We therefore believe that no special funding authority is presently needed to establish special new emergency shelters.

In using any facilities, we would propose using State and tribal licensing requirements as we do under the Indian Child Welfare Act. We do not support the concept of compensation to Indian families providing emergency shelters to juveniles. The number of available families with adequate facilities to provide these services is limited in the reservation setting and if the juvenile is not provided with counseling or other necessary services the home simply provides a holding facility that in many cases would not be adequate to deal with the needs of the youth.

There are several provisions in the bill that pertain specifically to Indian Health Service and we would defer to Indian Health Service to answer those questions. I will not elaborate on those.

We applaud the Congress in attempting to address this very serious and complex problem, but for the reasons outlined above we oppose both of the bills. However, we would be pleased to work with the Committee in addressing these problems.

This concludes my statement.

Mr. MOODY. Thank you.

It sounds as though your opposition is based more on some of the drafting language than on substance.

Mrs. ELBERT. That is essentially correct, Mr. Chairman.

Mr. MOODY. Maybe there are ways of redrafting or modifying those bills which would make them acceptable. Is that accurate?

Mrs. ELBERT. I would think we would be able to work with the Committee to work out some of the problems that we have with the bill.

Mr. MOODY. Thank you.

Mrs. ELBERT. Mr. Chairman, I would also like to offer for the record a copy of our newspaper "Linkages", which we just published and is now in the mail to all of the recipients.

Mr. MOODY. We will be glad to put that in the record. Thank you.

[EDITOR'S NOTE.—At time of printing, the Department had not yet supplied the above-mentioned newspaper. When received, they will be placed in the committee files of today's hearing.]

Mr. MOODY. Let's see if the committee members have questions. The gentleman from Arizona.

Mr. MCCAIN. Madam Secretary, I thank you very much for your statement of desire and commitment to address this issue. I am a bit intrigued at your statement that you object to the legislation as drafted. I see numerous objections to H.R. 1156, but I do not see any objections to H.R. 2624. Perhaps you could tell me where it is that you object to H.R. 2624.

Mrs. ELBERT. I believe the bills are essentially the same except in some areas where the Indian Health Service or the Department of HHS would be required to do some things different than what is in H.R. 1156, and it was in those areas where we deferred to HHS for response.

Mr. McCAIN. I understand that you referred them to IHS for a response, so you basically took it out of your area of responsibility. Can you tell me where the BIA objects to H.R. 2624?

Mrs. ELBERT. I believe the way it is drafted, where it touches upon those areas that I elaborated on here, we would object to those.

Mr. McCAIN. Madam Secretary, I see nothing in your statement that objects to H.R. 2624. You were asked in your testimony to show the areas where you objected. I see numerous objections to H.R. 1156, which are areas which are different from H.R. 2624. I hope you will go back and look at H.R. 2624 and illuminate the committee on the areas where you are objecting to H.R. 2624.

I also would like to follow up on the chairman's statement and elaborate a bit. Do you agree that not enough is being done to combat the problem of alcohol and drug abuse on Indian reservations in America today?

Mrs. ELBERT. Mr. Chairman, this is such a serious problem with the Indian people in Indian country today that I do not think we can do enough at the moment. This bill is not enough. Anything that we can do would simply not be enough to combat the problem.

Mr. McCAIN. Thank you. Do you think that we are doing enough at the present time?

Mrs. ELBERT. My own personal view is, no, we are not. We are doing as much as we can, I think, within our available resources.

Mr. McCAIN. I understand that and appreciate that, and I appreciate your efforts and those of your organization. If not enough is being done, though, outside of the amounts of funding and authority that your office has, is there a need for us then to take additional steps to try and address the problem with bills such as that of Mr. Daschle and Mr. Bereuter's and my own? Would you agree with that?

Mrs. ELBERT. Yes, I would agree with that. That is why we would be happy to sit down with the committee to work on the bills to reach agreement on how we think they should be drafted.

Mr. McCAIN. Good. I look forward to that opportunity and I wish that we had done it some time ago.

I would like to just mention a couple of things about your statement where you list 122 alcohol and drug abuse programs in place in schools. Madam Secretary, I have to say that is a bit misleading. There are programs listed which are funded strictly by the tribes; there are programs which are occasional, yearly; there are programs which are simply not phased in at this time. There is ample evidence that many of the 122 that you list simply are not programs. I am not accusing you of falsehood. Please don't get me wrong. But one gets a different impression from your listing when you investigate how really meaningful and substantive these programs are.

I agree that efforts are being made, but I would just like to give you an example of Chinle, which is numbers 2 through 11 on your list. These schools are identified as having a program operated through a "Navajo Alcohol Program." It is my understanding that this is a 3-day, 3-phase program provided once a year. I think that is somewhat different than the kinds of impressions that might be conveyed.

The only reason why I am bringing that up is because it is the opinion of this member that we need to do a lot more. I think we can do a lot of it with existing funds. One of the parts of my bill which I think is very important is to identify those areas which are in near crisis status and devote efforts to those areas. This is not unusual. It happens in every Department and even in this convoluted body. We identify an area of crisis, such as the budget crisis. Then we put in our best efforts and talents and devote them to that. We have areas of crisis on Indian reservations today, and I think we must identify those areas and devote our resources and efforts to the worst areas first.

One of the things I have learned about Indian reservations, is that they are not all the same. In fact, they vary dramatically, economically, social advancement, educationally, in every possible way. It seems to me that if we enact blanket programs we may not be focusing on the areas which are of the most critical importance. They are all important, but there are certain areas that need our immediate attention.

I think the lady to your right would like to rebut. Would you identify yourself, please.

I am sorry for taking so much time, Mr. Chairman.

Ms. **Garrett**. I am Nancy Garrett, Deputy Director of the Office of Indian Education Programs. Congressman, it is not so much to rebut. The Navajo alcohol program represents, I think, an enormous commitment on the part of the Navajo Tribe to provide an alcohol and drug abuse prevention program for the schools on the Navajo. In the case of Chinle, it is true that speakers from the tribe do come in for a certain number of days throughout the school year and make a presentation. However, the schools in the Chinle, as well as the other schools on Navajo, have tried to integrate into their health program the basic thrust of that program developed by the Navajo Tribe. So while there is certainly what you said, that special 3- or 4- or 5-day emphasis, there is also woven into the curriculum of those schools, in the health component of the curriculum, a recurring message on alcohol and drug prevention.

Mr. **McCain**. Thank you. I appreciate what you say, and I also appreciate the commitment of the Navajo Tribe to this effort, but I think the bottom line is, what has been the overall effect of these programs? I think that the testimony of tribal chairman after tribal chairman, tribal councilman after tribal councilman will be that we have not made any progress; in fact, the opposite result has been true. And that is why I hope that we will be able to work together to develop legislation which will more adequately attack the problem.

I would like to say, Mr. Chairman, in all candor, it may cost money. The point was made by the previous witnesses that the amounts of money that are being spent by Indian Health Service today on problems that directly result from alcohol and substance abuse far exceed any imaginable amount of money that might be enacted by any legislation on this issue.

I thank you for your indulgence.

Mr. **Moody**. Thank you.

Before I turn to the other members of the panel, let me just follow up on a point or two. You said that we are not doing enough today but that we are doing the best within existing resources. I think I am summarizing you correctly. Don't you feel that existing resources might be reorganized to do more? That has been some of the conclusions in the testimony already received, that some of these programs might be streamlined, dovetailed, consolidated. Are you saying we are optimizing our existing resources?

Mrs. Elbert. At the moment I do not believe we are optimizing those existing resources. The BIA does not receive appropriations specifically for alcohol and drug abuse. However, if there was some coordination between our programs that we do implement in the human service area and Indian Health Service, which does receive funds for this purpose, I think, to some extent, we could probably better use the funds to address these problems.

Mr. Moody. So you do agree that more coordination is needed?

Mrs. Elbert. I do agree that more coordination can be carried on with Indian Health Service.

Mr. Moody. In light of your comment that we are not doing enough, perhaps it would be appropriate after some of the details are worked out that the statement of your Bureau would be that you support these bills rather than oppose them, but with reservations.

Mrs. Elbert. I think that is what we are saying here already.

Mr. Moody. Thank you. I would like to have it on the record that in effect you are saying you support the goals of the bill but you have some reservations about some of the concepts of the bill.

Mrs. Elbert. Yes, sir.

Mr. Moody. Thank you.

Mr. Richardson.

Mr. Richardson. Thank you, Mr. Chairman. I will make a brief statement and then perhaps reserve the balance of my time for after we return.

Mr. Moody. Yes. We have a quorum call in a few minutes.

Mr. Richardson. I do not want to cast gloom on this hearing, but this is the third hearing that I have attended and the BIA's response has been identical in these three same hearings. I commend Mr. McCain and Mr. Bereuter.

I think the BIA has blatantly failed. Mrs. Elbert, I do not mean you personally. I think you are a fine professional. But I think to say that the BIA shares the goals—sure, we are all against Indian juvenile alcoholism, but the performance is almost nonexistent.

This is the third hearing I have been to and I hear the same kind of response to the most serious problem on the Indian reservation. We could save money on law enforcement and social services if we just work together to generate more programs. I do not think it would mean necessarily more money but with existing resources.

You are talking about 122 programs that you have in place in the schools. I can tell you three right now that I think you are including in your 122, the Navajo Chinle, Fort Defiance, Eastern Navajo Agency, Navajo Alcohol Program, where you are not contributing at all. It is the State of Arizona, the State of New Mexico, the IHS. I do not understand where there is this overwhelming view that you have a commitment towards doing something. I just do not see it in policy, in deed, in funding.

The BIA has been without an assistant secretary for about 8 months now. Maybe that is the problem. I do not know what it is.

I think, Mr. Chairman, we have got to enact Mr. McCain's bill or Mr. Bereuter's bill to provide some direction. We are going through a phase of (histrionics) here. There is no action.

I respectfully disagree with my good friend from Wisconsin. Sure, their intent is there. We are all against Indian alcoholism, especially among young kids, but where are the deeds? Where are the programs? Where are the ideas? Where is the commitment? Where is the coordination? I think unless the Congress takes a leadership role we are not going to do anything.

Mr. MOODY. While I give Mrs. Elbert a chance to organize her answer, we will take a break for a roll call.

AFTER RECESS

Mr. DE LUGO [presiding]. Madam Secretary, we will continue. I am going to sit in for Bill Richardson, who I think will be here in a few minutes to take over as Chairman.

When we broke I think you were going to answer a question. The Chairman said you might take that time to prepare your answer.

Mrs. ELBERT. I believe Congressman Richardson had made a statement. I do not have a rebuttal, if that is what we want to call it, to the things that he said. A lot of the things he said in his statement were true. We have been without an Assistant Secretary for Indian Affairs for well over 8 months, and there is an awful lot that needs to be done. If there is anything done legislatively, I think probably it should be done within existing resources. I believe he said that he did not feel that anything was going to get done unless it was mandated by legislation. My thought on that is whatever is done we should do it within existing resources.

Mr. DE LUGO. My recollection as to what Congressman Richardson was saying was that he attended three of these hearings and heard virtually the same things, that nothing had come of them, and he was obviously very frustrated. I must say that when I was listening I looked at the Department's statement. At first I thought, well, you are opposing the legislation, but as you testified, Madam Secretary, I was very glad that it was brought out that in fact it is more a question of drafting. At that time I made an aside to somebody and I said, "Why, don't we just adjourn this meeting and start working on the legislation and then get back and move some legislation?" Because while we are here talking, alcohol and drugs are destroying the lives of young people.

Mr. McCAIN. Mr. Chairman, if I could comment on your comment.

Mr. DE LUGO. Yes.

Mr. McCAIN. We are also going to need that kind of commitment on the part of IHS as well as the Office of Management and Budget. As we know from our previous experience, sometimes the Office of Management and Budget is less than desirous of participating to help draft legislation which costs additional moneys.

While we are waiting for Mr. Richardson, I would like to ask unanimous consent that we have 3 to 5 days to submit questions for the record.

Mr. DE LUGO. Without objection.

Mr. MCCAIN. I think it is important also that we recognize that this problem has been exacerbated by the reductions in overall fundings that have taken place over the last five years for all BIA and IHS budgets. I do have some sympathy for the Secretary here. If funding for other programs is reduced, that reduces economic opportunity, it reduces hope, which may lead to the obvious recourse to drug, alcohol, and substance abuse. We are on a downward cycle, I think a case can be made, and I would hope that the IHS representatives, our next witnesses, would also want to join us in helping to draft legislation which would be acceptable to the administration.

Thank you.

Mr. DE LUGO. Thank you, Mr. McCain.

Let me also say this. When we deal with the question of alcohol and drug abuse there are many that still do not accept the fact that alcoholism and drug abuse can be cured, at least that you can live a day at a time and live a good life. There are many who are still blind to what we have discovered about alcohol and drug abuse just recently within the last 10 or 15 years. We are not talking about some meaningless exercise here; we are talking about something that has been proven in the last 10 or 15 years to be a way of saving lives and of avoiding a tremendous amount of misery. Of course if we can do it through education to avoid the addiction, that is the best way. If you do have the problem of alcoholism and drug addiction, then there has to be a cure or the hope that the person can live a normal and productive life. We know that this can be done. But it takes a commitment and it takes something more than all of us just talking about it.

I did have one question. Madam Secretary, it was brought out by several of the members here that in your 122 alcohol and drug abuse programs that are in place in the schools that in fact many of these are not active and many of them are very short term. In fact, some of them are 3-day programs. Do you think that a 3-day program is adequate?

Mrs. ELBERT. I would like to refer to Nancy Garrett to answer that question. I am not sure that that is what is happening here, whether these are 3-day programs or 1-day programs, or what have you. I think Nancy would be able to give you a little more detail about them.

Mr. DE LUGO. That is our information.

Ms. GARRETT. Mr. Chairman, as we were discussing with Congressman McCain, there are programs that are 1 day, 2 days, 3 days, 1 week. The specific programs that we were talking about on Navajo are a 3-day focus basically once a year as an attempt to make children aware of how damaging alcohol can be to their bodies. I went on to say that we have tried to take the thrust of that program and build it into the health curriculum in those schools. While that still does not go far enough, and I would be foolish to sit here and say that we have done everything that we can, nonetheless our focus on alcohol and drug abuse has been primarily over the last 2 years. We admit that there is a lot more that we can do, but we also say that we have made a beginning. Certainly a 3-day program is a start. We need to work harder at building it into a regular curriculum. Maybe not just in health; maybe in history; maybe in social studies; maybe in other programs.

Mr. **de Lugo**. Obviously a 3-day program is a start. Let me ask you this. What does the Bureau consider adequate and effective preventive education?

Ms. **Garrett**. Mr. Chairman, it would be difficult to define the word "adequate" in the context of the hugeness of this whole issue on reservations. One of the things that we say in our testimony is that we have just recently entered into an agreement with the Office of Juvenile Justice and Delinquency Prevention at the U.S. Department of Justice for a special emphasis in about 50 of our schools, touching the lives of as many as 10,000 children. It is a very aggressive effort to make children aware, as I said, of the psychological, physiological, and sociological effects of alcohol. While I cannot really define the word "adequate," we are searching and looking, like public schools around this country, for how far do you go in providing prevention programs in our schools.

Mr. **de Lugo**. With all this misery and everything, at some point it should be determined what is considered by the Department adequate and effective preventive education programs to be conducted in the classroom with the students. I just feel we should get on with the legislation.

Mr. Chairman, I have no more questions.

Mr. **Richardson**. [presiding]. Thank you very much.

Mrs. Elbert, once again, we have worked with you and Nancy Garrett, and my comments earlier were institutional and not directed at both of you. If you still remember what I said, would either one of you like to respond?

Ms. **Garrett**. We did in your absence, Mr. Chairman.

Mrs. **Elbert**. I do not have anything to add, Mr. Chairman.

Mr. **Richardson**. Summarize what you said. It is of interest to me.

Mrs. **Elbert**. I guess what I really said was that I did not really have a rebuttal to what you said. It is true that we have been without leadership for a good long while, I believe in excess of 8 months. We are getting pretty close to 1 year now. Maybe that does have some bearing on what we have done or what we have not done in this area.

Mr. **Richardson**. Does Mr. Hodel care about Indian issues? Is he involved at all?

Mrs. **Elbert**. I am certain Mr. Hodel cares about Indian issues.

Mr. **Richardson**. Well, thank you both.

Our next witness is Dr. Robert Kreuzburg, the Acting Deputy Director of the Indian Health Service. He is accompanied by Dr. Craig Vanderwagen, the Acting Director of the Division of Clinical and Environmental Servies, and Mr. Russell Mason, Chief of the Alcoholism Branch Program.

Gentlemen, welcome to the committee. In the interest of time, your statement will be inserted in the record and I would like to have you summarize, if you could.

[Prepared statement of Dr. Robert Kreuzburg may be found in appendix I.]

STATEMENT OF DR. ROBERT KREUZBURG, ACTING DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. CRAIG VANDERWAGEN, ACTING DIRECTOR, DIVISION OF CLINICAL AND ENVIRONMENTAL SERVICES; AND RUSSELL MASON, CHIEF OF THE ALCOHOLISM BRANCH PROGRAM

Dr. KREUZBURG. Our opening statement generally goes to the fact that the Department opposes the enactment of the two bills and then goes into what we are doing and why we would indeed oppose the enactment of the bill.

The Department and IHS certainly share the concerns of the committee and Indian communities that have worked so hard on developing these bills. We are quite aware and have been involved in some of the development of the bills and have worked with some of the staff of the committee in helping with these bills. We feel that in general we have the legislative mechanism to carry out the majority of the items that are mentioned in this bill at the present time.

We have known for some time about alcoholism and drug abuse, which we prefer to call substance abuse, because studies are showing that they really aren't separate; they should be combined, you can deal with them the same way. We have been aware of that for many years.

Under the previous funded and directed programs that were begun in 1976 we interpreted the intent of Congress to be that most of those programs funded through the alcoholism appropriation dollars were to be directed toward treatment. Since 1983, which you mentioned was the beginning of looking at prevention as a real effort, and then really getting on board in 1984 and now on into 1985, we have begun to redirect the efforts within the Indian Health Service at prevention, with the understanding that we still have the congressional intent of those alcoholism programs towards treatment.

As a result of that, much effort has already gone into altering our approach at dealing with alcoholism and substance abuse. The Indian Health Service is taking great strides in trying to redirect our available resources to address prevention as compared to treatment. That was prior to the introduction of these bills but also subsequent to having reviewed these bills. The Senate's bill obviously has influenced our thinking in our programs, and we are already moving in that direction.

We do have a lot of programs that are described in here that show that we are doing innovative things. When I use the word "we" I don't mean to imply that it is just the Indian Health Service. I think you must remember that the "we" is the Indian communities, the Indian Health Service and all the other resources that are provided to Indian groups.

Many of the Indian alcoholism programs that we have funded over the years have additional funds and resources from the states, as was mentioned. So it is not just the Indian Health Service budget that is providing alcoholism services. Through the dedicated efforts of the Indian community they have sought out other resources to address this issue.

It is quite clear to us that the Indian community is the key. New studies have shown that the young people, who are the highest risk, are those who lack the support of family, home, community, have a poor image of themselves, have poor self-esteem, and many of the programs that we are beginning to look at now are beginning to address those needs, which indeed can be met through education but also through the health arm, which is IHS.

So we have several programs across the country already that are beginning to deal with that issue. And that is relatively new. Nineteen eighty-three is not long ago and the effectiveness of those programs is hard to measure in just 2 years.

In our opening statement we have presented some of those interesting ways that we have been trying to address the alcoholism problem among even the very young, down to the kindergarten age.

Specifically in regards to why the Department would not want this legislation, as I mentioned originally, we feel that most of these things could be carried out within our present legislative rules and regulations, and therefore as a result of this we are beginning to look at ways to do that. That means redirecting available resources that we have to make programs more efficient, but also to reprioritize our health needs and indeed make sure that we do not negatively impact on any services, such as maternal and child health efforts or other activities that we might have to redirect funds from.

Specifically—and I think it was asked of the BIA—in regards to the two bills, there are some things that we mentioned in our opening statement that we specifically oppose in relation to those. One is in H.R. 2624. We oppose the establishment of an Office of Indian Juvenile Alcohol and Drug Abuse with a mandatory organizational structure. We feel that that should be carried out by the existing staff and mainly in the field, which is the key, because more and more evidence is the communities have to be involved if you are really going to make an impact on prevention.

We also believe that the two bills contain redundant authorities. They call for authorities and activities at a national level which can more effectively and economically be done at the local level. It would dissipate available resources by directing them into producing national reports and studies and away from services and have unrealistic schedules for these reports.

We already have announced that we are in full agreement, as the BIA was, with a formal agreement with the Secretary of the Interior if we need to. I think, though, there is ample evidence, at least at the local level when you get down to actual working where the people are, that regardless of the bureaucracy the people are working together. But at the central level, as we said to the Senate, we don't quite get along.

Mr. RICHARDSON. Just like the Congress.

Dr. KREUZBURG. The length of time for the reports and things seems a little bit short and creates a burden that could take away from the delivery of services.

Title III of H.R. 1156 and section 4 of H.R. 2624 mandates certain family and social services training activities which the President's budget does not contain funds for, and therefore we obviously would oppose those.

Section 502 of H.R. 1156 is based on the premise of the Secretary of Health and Human Services having the sole responsibility for residential alcohol and drug abuse treatment centers for Indian juveniles. We believe this could go beyond the health related authority and responsibilities that were transferred to the Public Health Service in 1954 and could remove or cloud those responsibilities remaining to the Secretary of the Interior.

There are a few more specific reasons why we would oppose or not some of the sections. We do, however, agree with the committees that this is a serious problem. I think that the Indian Health Service has taken the work that these committees have done, from the testimony in the field that we have seen and participated in, and is addressing these needs within the available resources and authority that we now have.

With that, I will be happy to answer any questions.

Mr. **Richardson**. Thank you.

Mr. McCain.

Mr. **McCain**. Thank you, Mr. Chairman.

Dr. Kreuzburg, I appreciate many of your remarks. I will try not to get too exercised as we discuss the issue here. I think your point that the Indian community is the key to solving this problem is certainly a very apt and important one. The Indian community in response to both Mr. Daschle, Mr. Bereuter and myself have overwhelmingly stated that they feel that there is a need for legislation, that there is a need for additional help, that there is a need for additional coordination among the programs and the agencies that are involved in this issue. They also feel that it is now the number one problem facing the young people of their tribes. I guess my question to you is, if the Indian community is the key, do you believe that there is no need for legislation?

Dr. **Kreuzburg**. We do not believe that we need this legislation because we have the legislative mandates already to carry out all except those that specifically we oppose, and therefore I believe we would be carrying out the wishes of the Indian community in addressing those that they also have raised to us in our alcoholism review meetings that we have already had this year.

Mr. **McCain**. Let me suggest to you, sir, that there has been a severe communications breakdown between you and the Indian community, because that is not apparent to the 20 tribes of the State of Arizona that I have visited personally and many other reservations across this country.

There are a couple of areas that I would like to discuss with you specifically.

You oppose training of community health representatives because the President's budget did not request money for these positions. I understand that you have to support the President's budget and work with the President, but I think it is also abundantly apparent that this Congress will not allow the Community Health Representative program to die, because we realize that it is the one vital link between preventive health and the hospitals that we

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have in the Indian community. Places like the Havasupai Tribe, whose reservation is at the bottom of the Grand Canyon, could not exist without a community health representative.

I think it is a bit unrealistic for you to object to our bill on the basis that the President's budget will do away with the community health representative when you and I know full well that that will be one of the last Indian programs that this Congress will see disappear, for very legitimate reasons.

I think you oppose any form of reformulation of the administrative responsibilities within the Department. You mentioned that there are 200-and-some-odd programs ongoing. I would say to you that a case can be made that one of the reasons why these programs have not made the impact that they were intended to is because of a lack of coordination. So I think there is a definite need for better coordination of organizations. As mentioned by a couple of my colleagues, it may not cost as much money as some people envision if we could get better coordination and implementation of existing programs as opposed to operating separate little empires throughout the Agency. That is one of the intents of this legislation.

I also hope that maybe you would appreciate that there is an overwhelming body of opinion within the Indian community believing that legislation is required. That in itself should be justification for you to reexamine your position as to whether it is or not, because we are trying to address the needs of the Indian community in America, not of the IHS, not of the HHS, not anybody else, nor any Federal bureaucracy. We are trying to address the needs of the Indian community in America and the Indian community in America is crying out for assistance.

So I would hope that you would reexamine your position and say that maybe there is a way that you could work together with Congress to try and come up with a piece of legislation so we can assure the Indian community in America that we are concerned and want to help. I can tell you that by coming here before this Committee and saying everything is either under existing authority or redundant, I think you are sending the wrong signal.

I hope you will reconsider your position and, as the previous witnesses from the BIA, display a willingness to sit down with the members of this Committee on a bipartisan basis—I am happy to say that Mr. Richardson, Mr. Udall and I and others have always attacked these issues on a bipartisan basis—so that we can hopefully get something meaningful accomplished. I would be more than happy to listen to your response.

Dr. KREUZBURG. I think we would respond the same as the Bureau of Indian Affairs. We certainly would be willing to sit down with the committee and the staff of the committee and work with them on addressing these issues. In the meantime, I think we would again state that as a result of all the work that has already been done we will be moving ahead to accomplish much of what is already in these under our existing authorities. We would certainly be willing to reexamine our stand on opposing the legislation.

Mr. MCCAIN. Thank you.

Thank you, Mr. Chairman.

Mr. RICHARDSON. Mr. de Lugo.

Mr. DE LUGO. Thank you very much, Mr. Chairman. I want to associate myself in the strongest possible manner with the excellent statement that was just made by the gentleman from Arizona, Mr. McCain.

Regarding the programs in your statement on page 3, those 219 contracted programs, how many juvenile admissions were there for the detoxification, primary residential treatment, halfway houses, and outpatient services during fiscal year 1984?

Dr. KREUZBURG. I will ask Mr. Mason if he can give us those numbers.

Mr. MASON. In fiscal year 1985 we had an inpatient load of 1,404, an outpatient case load of 3,312, for a total of 4,716 that were referred or came to our residential or our alcoholism programs for treatment.

Mr. DE LUGO. How many of those were single encounters and how many were repeat encounters?

Mr. MASON. These are all single encounters.

Mr. DE LUGO. No repeat encounters?

Mr. MASON. Not according to our information.

Mr. DE LUGO. Page 3 of your statement. How many juveniles and adult admissions were there in fiscal year 1984 for treatment in the 48 IHS hospitals and the 200 clinics?

Dr. KREUZBURG. Total number of discharges for alcoholism and drug dependence age 15 to 24 years with all our facilities, including those that we contract with—I don't have it separated by just our 48 IHS facilities on this sheet, sir. We could probably find that and probably break that out for you—I'm sorry. It is broken out. There are 297 discharges in our direct facilities, which would correspond to the 48 that you mentioned.

Mr. DE LUGO. Is this number increasing over the years? And what is the average cost per patient for detoxification treatment?

Dr. KREUZBURG. I think we probably will have to provide that for you, sir, to answer that specifically, to break it down that way.

Mr. DE LUGO. I would like to request, Mr. Chairman, that that be done.

Mr. RICHARDSON. Without objection.

[EDITOR'S NOTE.—At time of printing, the Department had not yet supplied the information requested by Mr. de Lugo. When received, that material will be placed in the committee files of today's hearing.]

Mr. DE LUGO. On page 3 you also state that IHS staff is working with tribal leaders, school and county government officials to help change community values which reinforce alcoholism and alcoholic behavior. Where and how has this happened, specifically?

Dr. KREUZBURG. Dr. Vanderwagen is closer to that.

Dr. VANDERWAGEN. I will just highlight for you one or two programs that demonstrate the dynamics of that activity. They are not necessarily directed strictly at substance abuse but rather look at overall approaches to Indian health and lifestyle. Last Friday on the Today program they featured the Zuni fitness program in Zuni, New Mexico. One of the features of that program is that it was originally targeted at dealing with diabetes. However, the impact in the community of having the community involved with the fitness program has led to a broader scale set of impacts, including that there is a decline now in substance abuse activity in that community. To give you relevant numbers, 2 years ago they started with approximately 3 exercise classes a week, and as of a month or so ago the community was running 50 exercises a week in that community of 7000 people.

The community response to a positive view of health has been tremendous and its impact has been felt in the school system where the health curriculum with a specific emphasis on substance abuse has just taken off, and we are seeing some real positive health impacts in that community. It is a model of the kind of program we would like to extend into other communities.

Another example that focuses around a BIA boarding school rather than a specific community emphasis is to be found at the boarding school in Chemawa where a model dorms project that was initially developed with BIA focuses on recreational therapies and recreational activities for kids as an alternative to substance abusing behaviors.

We do have some data on the program at Phoenix Indian School and the Truman Institute that we think embody many of those same kinds of dynamics, and we look forward to data being generated from those programs to really substantiate our belief that these are the kind of programs that have the broadest impact on the youth in Indian country.

Mr. DE LUGO. How does IHS presently evaluate the effectiveness of its programs? In your professional opinion, is this an appropriate method, and how long has IHS used the present rating system?

Dr. KREUZBURG. I will ask Mr. Mason to describe the process. But I think, yes, we do look at that as a way of measuring the effectiveness of that, and it has just been completed, so we are evaluating it.

Mr. MASON. The first evaluation that we did and completed 2 years ago was we looked at the administrative part of the program basically to establish some accountability, and this was after the transfer from NIAAA to IHS. In our last evaluation, which was completed 1 year ago, we looked at the appropriateness of the program primarily to measure outcome, looking at outcome in terms of those clients or patients who had completed negotiated treatment plans. I think that we found that the majority of the programs were successful or were providing successful treatment to the clients.

Mr. DE LUGO. I have no further questions, Mr. Chairman.

Mr. RICHARDSON. Thank you very much.

Doctor, I am going to be nice to you because you have one of my constituents with you, Dr. Vanderwagen. I do have three questions that I want to ask you, and most of them are statistical.

You say you have 219 substance abuse programs. How many of those programs and how much of the $25 million alcoholism budget that you have is directed toward Indian youth and preventive efforts among youth?

Dr. KREUZBURG. I do not know that I can say how much to Indian youth. I can say that of the 60 percent of the tribes who responded to our questionnaire 88 percent of them reported prevention efforts. Only 30 percent of the IHS funded programs have prevention services, but they had changed their structure such that prevention becomes a part of it.

This is new. It really is new. In the past treatment was the emphasis. Now prevention is. These programs are now just coming on board of redirecting their resources that they are given, and that takes a significant change in their management of those programs and has an impact on economy and work load, et cetera.

We were amazed to find that of these programs 88 percent of them are now talking prevention, looking to prevention as being important; 30 percent of them actually are providing those services just in a matter of 2 years.

Mr. **Richardson**. But you don't break down in age groups? Do you have a ballpark figure? How many under 21, perhaps?

Mr. **Mason**. We have just recently completed a prevention inventory that we initiated. I will be going out to Albuquerque next week to meet with the people and we will have a final report, and I am sure that we can get that type of information.

Mr. **Richardson**. I would like you to provide that for the record. I think that is basic information that we need. That 88 percent sounds good.

What is the annual cost to IHS of related clinical treatment of alcohol abuse, trauma, drug related trauma, drug related disease? Do we have any idea?

Dr. **Kreuzburg**. I think it would be hard to give an absolute figure. We were trying to answer that sitting there in the audience. We would say that in addition to the alcoholism dollars we would estimate we are talking $10 million worth of other activities within our budgeted categories, hospital care for the trauma. There has been a significant amount of work on trauma, and it goes way up when you list all of the trauma. It depends on how you look at those numbers and how you break them out. It is obviously very high.

Mr. **Richardson**. I did notice a little lack of synch between BIA's statement and yours on these bills. In other words, BIA said the bills sound good and aren't so bad, and you said the bills don't sound too good and don't look too good either. If that makes any sense. My question is on coordination. You mentioned formal agreements. How many formal agreements are there between IHS and BIA right now relating to alcoholism?

Dr. **Kreuzburg**. I would say we have no written formal agreements.

Mr. **Richardson**. Are any in the works?

Dr. **Kreuzburg**. The Secretary had indeed written a letter stating that we are willing to do that, but I do not think we have consummated that formal written agreement. There has been communication as a result of the Senate hearings since that time with IHS and the central Bureau in regards to these issues, but as far as I know there are no written formal agreements.

Mr. **Richardson**. Wouldn't formal agreements be helpful? Again, my colleague said we are talking about helping Indian people, not streamlining and assisting bureaucracies. In this case wouldn't it make sense to have some formal agreements, given the magnitude of the problem?

Dr. Kreuzburg. Yes, and I think the Secretary of our department has agreed that that would be useful.

Mr. Richardson. Who is that now? I can't keep track anymore.

Dr. Kreuzburg. Secretary Heckler is still performing her duties.

Mr. Richardson. I will not pursue that.

Dr. Vanderwagen, is there anything you would like to say?

Dr. Vanderwagen. No.

Mr. McCain. Mr. Chairman, I ask unanimous consent that further questions may be submitted. Also I ask unanimous consent to add at the end of my prepared statement the letter from Mr. Norman Austin, the council chairman of the Fort McDowell Mohave Apache Indian community.

Mr. Richardson. Without objection.

Mr. McCain. Thank you.

Mr. Richardson. Thank you.

We now will continue our hearing. I would like to have the following witnesses step up to the witness table.

Mr. Mel Sampson, chairman, Northwest Portland Area Indian Health Board; Mr. Ray Field, executive director, National Tribal Chairmen's Association; Ms. Suzan Harjo, the executive director of the National Congress of American Indians and also representing the National Indian Health Board; Mr. Steve Unger, the executive director, Association on American Indian Affairs, accompanied by Mr. Jack Trope, staff attorney.

Welcome to this Committee. Your statements will be inserted in the record. I will ask you to summarize your statements. I would like to call on Mr. Sampson first.

Once again, your statements will be fully inserted, and I would like each of you to summarize your statements and we will go on the 5-minute period so that we can have some questions also.

Mr. Sampson, please proceed.

[Prepared statements of Mel Sampson, Ray Field, Suzan Harjo, with attachment, and Steve Unger may be found in appendix I.]

PANEL CONSISTING OF MEL SAMPSON, CHAIRMAN, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; RAY FIELD, EXECUTIVE DIRECTOR, NATIONAL TRIBAL CHAIRMEN'S ASSOCIATION; SUZAN HARJO, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS; AND STEVEN UNGER, EXECUTIVE DIRECTOR, ASSOCIATION ON AMERICAN INDIAN AFFAIRS, INC., ACCOMPANIED BY JACK F. TROPE, STAFF ATTORNEY

Mr. Sampson. Mr. Chairman, my name is Mel Sampson. I come to you as the vice chairman of the Yakima Tribe and the chairman of the Northwest Portland Area Indian Health Board. We appreciate this opportunity to make our presentation and concerns on H.R. 1156 and H.R. 2624. The area board represents 37 federally recognized tribes in the States of Washington, Oregon, and Idaho.

We have been extremely concerned over the years about the low level of resources that have been available to our tribal alcohol programs. Because most of our small tribes did not have the grant-writing capability to receive NIAAA grants in the days when the grants were available, many of our tribes are not now able to receive alcohol program funds through the Indian Health Service as, with a few small exceptions, the Indian Health Service only funds prior NIAAA grantees. This has caused extreme hardship throughout our area, leaving many communities with few or no resources to address the substance abuse epidemic.

We want to take this opportunity to applaud the emphasis on prevention in H.R. 1156 and H.R. 2624. Because of the overwhelming caseloads of adult substance abuse, Indian alcohol programs have historically paid little attention to prevention.

The board is in full agreement with the testimony on these bills that has been provided by the National Congress of American Indians and the National Tribal Chairmen's Association. We obviously are disappointed with the presentation that has been made by the Indian Health Service as well as the Bureau of Indian Affairs.

Just to briefly summarize our concerns with reference to the respective titles.

Title I, the Inter-Departmental Agreement. We support the concept of agreements between the Bureau of Indian Affairs and the Indian Health Service to coordinate programs and delineate responsibilities for alcohol and drug abuse programs. As far as we know, in our area there are absolutely no existing agreements between the Indian Health Service and the Bureau of Indian Affairs.

We are not in favor of the proposal in H.R. 2624 to establish an Office of Juvenile Alcohol and Drug Abuse within the Alcohol, Drug Abuse and Mental Health Administration. We would suggest that this be located within the Indian Health Service for better coordination with tribal programs.

We are also unsure of the existing program funds to designated crisis areas as specified in H.R. 2624. We would recommend establishing a newly appropriated "crisis fund" to be administered by the Indian Health Service headquarters to deal with emergency situations.

Title II. We believe that training of school counselors in the Bureau of Indian Affairs and tribal and public schools is essential and endorse the amendment of the Indian Elementary and Secondary School Assistance Act for this purpose. We also agree with the establishment of a priority for training in this area through the Indian Education Act as provided in H.R. 1156 under section 202.

We fully support section 205 of H.R. 1156, which requires the establishment of summer recreation and counseling programs for Indian youth on reservations.

The national BIA sponsored newsletter on Indian alcohol and drug abuse, as required in section 206 of H.R. 1156, would be an excellent means of providing information and coordination of alcohol and drug abuse related material and resources to Indian people. We would have a problem, though, with sandwiching the topic of alcohol and drug abuse with an Indian child welfare linkages newsletter as the Bureau suggests, as each topic warrants special attention to its respective subject matter.

Title III, Family and Social Services. We strongly support the training element that is contained in all aspects of title III.

Title IV, Law Enforcment. The training of BIA, tribal and federal law enforcement personnel is essential in any effort to prevent or combat juvenile substance abuse as the lack of consistent enforcement of substance abuse laws is one of the biggest problems in this field.

Obviously a major problem that faces probably all areas, especially in the Northwest, is that there is a total lack of adequate facilities. Consequently we have to rely upon the utilization of jails, not only tribal jails, but county and city jails.

The requirement that the BIA establish a program for Indian households to be compensated to serve as temporary emergency shelters for substance abusing youth we feel is an excellent idea that would serve well in areas without regular emergency shelters if the tribal members are trained to deal with the cases.

Title V, Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation. This has a specific concern to us Northwest tribes because the Northwest has no Indian Health Service hospitals. The establishment of comprehensive treatment services in Indian Health Service and "638" inpatient facilities, as directed by H.R. 1156, would not meet the needs of our juvenile population. Two youth treatment centers separate from hospitals are needed in the Northwest. Services to communities lacking IHS hospitals are addressed in section 503 of the bill, which we fully support.

Title VI, Definitions, Effective Date, and Authorization of Appropriations. We feel that in this section it should be made clear that the term "drug abuse" includes the abuse of inhalants. Inhalant abuse is a growing area of concern among our Northwest tribes and requires special education and intervention techniques.

Essential to the accomplishment of the provisions of H.R. 1156 is that the appropriations be adequate to permit accomplishment of the various objectives. We are not sure that $5 million is adequate to this task. "Such sums as may be necessary" might be more appropriate language.

The requirement in H.R. 2624 that tribes or tribal organizations provide 25 percent of the cost of the program would not be realistic for most of our Northwest tribes. Areas where the need is most urgent would not be able to participate at all. So therefore we oppose the matching fund concept.

With the changes noted in our testimony, the Area Board believes that H.R. 1156 is an outstanding bill which will provide the needed programs and coordination to combat the problem of juvenile substance abuse. We want to commend you for your approach on this.

Thank you.

Mr. RICHARDSON. Thank you, Mr. Sampson.

Mr. Ray Field.

Mr. FIELD. Thank you, Mr. Chairman. I represent the National Tribal Chairmen's Association at this hearing. We are comprised of 183 federally recognized tribes.

Our Indian people are deeply concerned about juvenile alcohol and drug abuse and the continued growing potential to harm and in many cases the destruction of our Indian youth. The problem has virtually failed to be addressed in a sufficient manner by either the IHS or the BIA.

Our concern increased when we heard about the nine tragic suicides on the Wind River Reservation in Wyoming. The potential for further destruction is quite alarming, as we realize suicide and substance abuse can be close comrades. To reduce this destructive potential, the National Tribal Chairmen's Association urges the Congress to integrate the following comments and suggestions to enhance the preventive and service aspects of the proposed bill.

As can be readily seen and heard in this hearing forum this morning, there is little coordination within the BIA and IHS, two congressionally mandated organizations charged with the responsibility of caring for the welfare and well-being of those tribes for which they have responsibility.

In section 101 expansion is needed to specify actual coordination guidelines and followup procedures for coordination of the BIA and IHS programs. For example. One of the functions of this section may be to refine information sharing of the more sophisticated programs so that the other programs may benefit and grow to better serve the students.

To determine the scope of the Indian Alcohol and Drug problem and its estimated financial and human cost, a survey tool can be developed by qualified and experienced employees. There should be input from alcohol and drug treatment centers, support groups, students, counselors and noted authorities in the field.

Under Title II, Education, section 204, a specific criteria of components must be listed as part of the alcohol and drug prevention program of instruction for BIA and contract schools. These components must include:

[1] A comprehensive curriculum indicative of current substantiated research.

[2] Suicide prevention information and a prevention plan addressing the high correlation between substance abuse and suicide incidents.

[3] Qualified and trained personnel. I am speaking of people who have undergone well designed, well disciplined programs.

[4] Involvement of support groups of Alcoholics Anonymous and Narcotics Anonymous.

[5] Peer counseling participation. I think we can all recall back to our childhood and how much we could have been helped, besides our parents or besides older people, by well grounded, well composed young people of our own age who can understand the problems that we undergo probably better than the older people who sought to guide us.

[6] A parent involvement plan will be established within the program to assist parents in how to recognize the problem and what they can do about it.

There is more, but that will be included in the record. I would like to genuinely express my personal appreciation and the appreciation of the National Tribal Chairmen's Association for the comments and the concern of the members of this Committee.

Thank you.

Mr. RICHARDSON. Thank you, Mr. Field.

Ms. Harjo.

Ms. HARJO. Thank you, Mr. Chairman. As you stated at the outset, this prepared statement is being presented on behalf of the National Congress of American Indians and the National Indian Health Board. We are very much in support of this legislation and we are very grateful to the committee for its lead in pushing this legislation through, and pushing it through does seem to be the business of the day.

The Indian young people are in distress. This is something we can do something about. We can prevent the situation from worsening. This legislation will help. It is not the be all and end all. What is in existence now is not working. There is no coordination. The BIA and IHS will not adequately address this situation if left to their own devices.

The Bureau of Indian Affairs and Indian Health Service were active participants in the drafting of this legislation, and I wonder just how it is that the administration came to oppose this legislation and now approaches it as they might literary criticism rather than actually rolling up their sleeves and trying to craft a law that will do something to ease the distress in our Indian community.

Sometimes we all have some enthusiasm for the Washington game that we have seen here today because of our general respect for the art of government and the substance of governments. Today I really have no heart for this game. It has been a real lesson in watching how Federal Agencies can say no in the most pleasing manner and escape with their hides. It has been a game about getting through a hearing; it has not been a game about crafting a law. I think it is outrageous, particularly in this International Year of Youth, that the administration would oppose such an important piece of legislation.

Thank you for your help. All I can say is pass the thing and let's get on with it.

Thank you.

Mr. RICHARDSON. Thank you.

Mr. Unger.

Mr. UNGER. Thank you, Mr. Chairman. My name is Steve Unger, executive director of the Association on American Indian Affairs. With me is Jack Trope, our staff attorney.

I would like to associate the Association with the comments of the representatives of other Indian organizations. I agree the time is now to get on with this important first and modest step toward dealing with this terrible problem among Indian youth.

I ask that our full statement be submitted in the record, and I would just like to briefly summarize some points here.

It would be very difficult for me to express how sad it has been for me to sit in this hearing room for the last 2 hours and hear what the administration has said. After all, in summary, what the Bureau has told us is that they have the authority and they point to 100-some-odd programs, many apparently begun within the last 2 years, as what they call a start. They have had the legislative authority, the Standing Rock Sioux Tribe pointed out to us earlier this year, since 1886.

They now, according to their own testimony, claim to be reaching 10,000 Indian children. That is less than one out of four of the Indian children who are the Bureau's direct responsibility to educate in the Bureau's own school system. At that rate, if my calculations are correct, we can assume that the Bureau in dealing with what again, according to testimony, it calls the most serious social and health problem facing native Americans today, at the rate they are going, I estimate that they will be able to reach all the students they directly educate, which is, of course, only a small fraction of all the Indian students needing their help, but they will be able to reach all the Indian students for whom Congress has given them a direct responsibility some time around the year 2285 with a 3-day-a-year program.

Mr. Daschle told us before that approximately 1 percent of the Indian Health Service budget is devoted to alcoholism programs. The administration in its fiscal year 1986 budget request has told us in black and white that they are recommending a further 1 percent reduction of that already pathetic 1 percent. Of course it would be more than a 1 percent reduction measured in real dollars.

Mr. McCain and a couple of other members of this committee earlier mentioned their impression that not only has there not been an improvement, but there appears to have been a regression in the last few years. Sadly, I think they are correct, and probably the alcoholism program coordinators are not entirely to blame for this, because it is something that goes beyond the question of alcoholism in Indian country.

Nationally the unemployment rate for all races has dropped 27 percent from 1982 to 1985, while the Indian unemployment rate, according to the Department of Labor and the BIA itself, has actually risen 7 percent during the same period. Risen 7 percent. As I think many of you know, you can go into Indian communities where the unemployment is 70 and 80 percent and the people do not even talk about it anymore because it is so taken for granted.

In our prepared testimony, using congressional reports we try to indicate some of the profound wounds to body and soul that this rate of unemployment creates. Yet ultimately it is immeasurable, of course. What happens to the Indian person who is employed, who escapes the alcoholism and drug trap?

Again, according to the BIA, 77 percent of employed Indian people on reservations are earning less than $7,000 per year. That is three out of the four American Indians who have jobs on Indian reservations. They are earning less than the high school junior or senior that comes to work in the Congress as a page earns, and these are adult American Indian people for whom obtaining a job is a very great accomplishment in life.

What the Association on American Indian Affairs sees basically is that perhaps what is most remarkable about this situation is not that there is a severe alcoholism and substance abuse problem on Indian reservations, but that so many Indian tribes and communities have managed to effectively cope with these situations and indeed have rates lower than might be expected in the general population, given the same degree of unemployment, hopelessness, despair, joblessness, and so on. Nevertheless, as you know and as this bill responds to, alcohol and substance abuse is a very great problem.

Again, because of the Bureau's testimony this morning, I would like to emphasize that one of the things that alcoholism and drug counselors point to as necessary to help prevent such problems is a stable, encouraging family environment, with parental care and supervision. For approximately 20,000 Indian children, 10,000 of whom are in the elementary grades, even their education means the absence of a normal family life. Today they are sleeping in BIA boarding schools and dormitories. Approximately 20,000 Indian children all together are today sleeping in BIA boarding schools and dormitories.

Every time Congress says let's provide day schools for all Indian families who want them let's emphasize, as Mr. Yates did a few years ago, getting day schools for the youngest children, under 10 years old. There are, by the way, 5,000 Indian children in BIA boarding schools and dormitories under 10 years old. Under 10. Every time Congress tries to do something the policy of Congress is grotesquely perverted by the Bureau, and instead of looking at providing schools for those communities most in need, the Bureau turns around and attempts to close the schools the tribes feel are useful to them in some way.

We have heard about the epidemic of alcoholism. I will finish in 1 minute. I would just like to again point out that this administration has either withheld support or actually opposed many of the programs that Congress has initiated to deal with alcoholism among Indian youth. One big example would be the veto last fall of the Indian Health Care Improvement Act which had important sections which addressed this.

I would like to ask Mr. Trope to address some of our specific concerns about this bill, which are basically to make it as sensitive as possible to specific needs of Indian tribes.

I would just ask one other thing. I am coming to this hearing from Alaska. I would also like to submit with our testimony an article from the Anchorage Times which talks about the pandemic of alcoholism and drug abuse among youth in Kotzebue. One of the people quoted in that article is the director of the social service agency in Kotzebue, who says about the youth there, "They don't know which way to go. There are no jobs and no pride."

So at least I think with this bill we can make a step towards addressing the latter problem.

Mr. RICHARDSON. Without objection, that article from the Anchorage Times will be inserted in the record.

[EDITOR'S NOTE.—At time of printing Mr. Trope had not yet supplied the article from the Anchorage Times. When received, that material will be placed in the committee's files of today's hearing.]

Mr. RICHARDSON. Mr. Trope.

Mr. TROPE. I won't go into great detail concerning the amendments that we have suggested for the bill. They are in our written statement, and we hope you will give them close consideration. Let me just hit on a few of the highlights, the things that we consider most important.

Before I talk about these things, let me reemphasize that we are in strong support of this bill, and these comments should not in any way be taken as indicating anything other than that.

Before I talk about the specific amendments, I would also note that if you look at the record of your field hearings I am sure that you will remember that many of the field people from BIA and IHS expressed a need for this bill. In fact, our assistant director indicates he was watching C-Span one day and Mr. Fritz indicated that he supported the bill. He is no longer around and so we cannot ask him about that, but I think it indicates that the opposition to the bill is probably coming from somewhere other than the people who really know what is going on out there. I would ask the committee to remember that.

In terms of the bill specifically, one thing that we want to emphasize is the importance of the provision in your bill dealing with recreational programs. The Senate version of this bill—and that is perhaps the major difference between the Senate version and the House version—does not include a provision dealing with recreational programs. We think that is crucial in any preventive strategy that is going to really work in terms of decreasing the incidence of youth substance abuse.

I would note the testimony from IHS. When they were asked about what kind of programs they had that are working in the alcoholism area, they talked about the Zuni program. Those are exactly the types of things that we would foresee as recreation programs. We think that can do more than almost anything to really have an impact on the problem. So we would urge you to keep that in this bill and in fact improve it, if you can. You can make it on a year-round basis where they are not otherwise present. We would like to see that. We have heard from many tribes throughout the country that recreational facilities are just not there for many, if not most, of their youth.

Another thing that we would like to emphasize is that we would like to see specifically that the training and education areas deal with the problem of inhalants and the problem, as Mr. Bereuter so eloquently pointed out, of fetal alcohol syndrome. I think people who are going to develop these programs need that specific direction that these are problems that need to be dealt with.

Inhalants are a problem more so on Indian reservations than perhaps in other areas of society, and often they may be overlooked in developing drug programs, because they are not as much of a serious problem in other areas of society. The inhalants are particularly devastating because it is the young children that use those drugs. The treatment for them may very well be different than the treatment for other mainstream drugs. So I would like to suggest that the committee specifically indicate that that should be part of the bill as well as the fetal alcohol syndrome problem, which, as Mr. Bereuter pointed out, is a major problem.

The third thing I would like to point out is that we hope that when you are amending the bill you will take into full account the need for local input and control. We believe section 102, which deals with the local coordination agreement, is excellent. We would like to see it include a planning component as well, and we would emphasize that whatever they do nationally in terms of coordination, it should be to facilitate this local coordination and not so that they can pat themselves on the back as having done something at the national level.

We would like to see those sorts of things incorporated throughout the bill. We would like to make sure that the training and the curriculum have tribally specific input. Mr. McCain indicated that tribes are very different throughout the country, and the training and education curriculum should reflect that.

Also, Congressman Bereuter mentioned the public schools. We would suggest that perhaps an amendment be made so that Johnson-O'Malley funds could be used to develop local curriculum in the public schools and Indian parents who head those committees could decide what to do with the funds, decide it is appropriate. That might be one amendment that would be useful.

We would also like to see families as a source of placement for youths in addition to these emergency shelters, because we feel that it is important to involve the Indian community as much as possible, and the Indian family is a very important resource.

I won't go any further with this. The last thing I would like to mention is the funding. A number of people have pointed out the cost of not doing anything, the cost to IHS, of incarceration. Those are very real costs. We would just like to emphasize that this bill should be adequately funded so that it will really have an impact in the Indian community.

That is really all I have. I would just refer you back to our statement for a lot of our specific recommendations in this area.

Mr. **Richardson**. Mr. de Lugo, do you have any questions?

Mr. **de Lugo**. I have no questions. I just want to say that the presention that you all have made here, as I have just been remarking to the staff, is as fine a presentation as I have heard. I only wish that the administration's presentation had been a fraction of the presentation you have presented here.

I certainly can identify with Suzan Harjo, your frustration and your remarks. There is something that I recognize here. I cannot understand how the BIA and the Indian Health Service can be so out of touch with people who are supposed to be their constituents. But then when I think about it I recognize it, because I come from a territory and there was a time when we were administered out of the Interior Department also. It was very colonial. It is a mind set; it is an attitude that the bureaucracy knows best.

We find that the administration people come in here defending the administration rather than trying to help their constituents, those that we at least see as their constituents or would hope would be their constituents.

The BIA secretary, after going through the Washington routine, at least said they'll work with us on the legislation. But I couldn't find anything redeeming in IHS's performance. It was just terrible.

Having said that, I again want to say that the presentation of each one of you has been what this committee needs. You have been specific; you have told us what you need; you have been constructive; you have told us where there might be some problems with this legislation; and you have made recommendations to strengthen the legislation.

There were some things that the administration said that I was just shocked by. The way they discounted putting the people in private homes. I think that would be a tremendously helpful thing, and I hear you saying that.

The matter of recreation that is in the House bill is tremendously important.

So I would just say, Mr. Chairman, that I hope that this committee will get on with moving this legislation, that this committee will indicate to the administration they have got a chance to work with the committee, work with us, and let's move this legislation, because there are people that are hurting and suffering and they need help.

Thank you.

Mr. RICHARDSON. I thank my colleague from the Virgin Islands. I share your view too that we need to move this legislation as rapidly as possible, and I believe, with the chairman's consent, we will do that.

You commended all these good people on their statement, and I agree. But what bothers me is the administration witnesses, as soon as they make their statements, they leave. That just bothers the heck out of me, especially when it is a subject where there are such wide differences.

Mr. DE LUGO. The press is gone too. The press is getting a distorted view too.

Mr. RICHARDSON. Yes. And that bothers me a lot. I don't know if we ought to pass legislation that mandates they stay. That's all we need, government intrusion.

Mr. DE LUGO. The Education Committee would have jurisdiction.

Mr. RICHARDSON. I wish to once again thank you for coming. I don't have anything to ask since I probably agree with most everything you have said. Some of the amendments that you have suggested we will consider.

Philosophically I want to express my sympathies with all of you, and especially Ms. Harjo. We could have switched roles here and it would not have made much difference.

We have to run off to a vote very soon.

I guess the thing that I am pondering is, what is the problem here? How can we deal with this issue? It seems that this is a good bill, but it is $5 million. It is really a very small drop in the bucket. To address issues like Indian alcoholism and Indian education, do we need a radical new departure in our relationship with the Indian people which maybe eliminates the BIA and just radically changes things.

I could sit here and tell you that maybe in 2 years there will be a Democratic administration that will support this bill and a Democratic administration that is more sensitive to Indians. Aren't we really talking about some fundamental changes needed in our relationship towards these programs, towards Indian tribes, and towards bureaucracies?

I see these problems first hand in my area. I just wonder if the direction we are heading in is the right one. You as Indian leaders, don't you really think we need a rethinking of the Federal-Indian relationship, a programmatic relationship with agencies in the approach to some of these problems? Aren't we just sort of sitting here and arguing over pennies?

How is that for a nonprovacative statement? You'll notice I say that when the press has left. Maybe just very rapidly, because there is a very damaging amendment coming up which we don't want to miss.

We will start with you, Mr. Field.

Mr. FIELD. Mr. Richardson, I think one of the things that is manifested by tribal leaders to us is the lack of cooperation with the two important agencies dealing with our tribes, the Indian Health Service and the Bureau of Indian Affairs. There is a lack of concern that is readily discernible in their activities and in the lack of them.

You have heard outrageous claims of 122 drug programs. We have not been able to confirm that with our tribes. The only thing we have heard from our tribes has been criticisms of the failure and the lack of interest in preventing juvenile alcohol and drug occurrences on their reservations.

We can adequately control those activities that impact on our people. If those activities take a direction that is adverse to our tribes, as we view the current IHS and BIA activities, then there is a need for drastic control. We want more control over what happens on our reservations. Those two agencies can act independently and discretionarily without any type of input from us. Yes, I agree with you.

Mr. **Richardson**. Ms. Harjo.

Ms. **Harjo**. Given this climate, I think that it would be very difficult to speak against the known system, because this administration is so willing to ignore everything we have said in other areas and wouldn't go along with any criticism we have of the Bureau of Indian Affairs and the Indian Health Service. Right now it would sort of be like legislating for the abuse, just waiting to get past this Administration.

Granted, there is no treaty that guarantees us 15,000 Federal employees. There are treaties that do guarantee health, education and protection against all manner of encroachment, and along with that we need some technical assistance, some advice, that sort of thing. But in this area in particular I think there might be room for a bold program with a lot of money, because you can't cure this without money. That would include a direct-to-tribes funding, not in a block grant sense, but in a logical sense. I think it would be good to explore it. Now, I think, is not the time.

Mr. **Richardson**. Mr. Sampson.

Mr. **Sampson**. I would like to direct my concerns and comments in reference to living on a reservation. Listening to what the headquarters personnel for Indian Health Service and the headquarters personnel for the Bureau of Indian Affairs say here and then what you hear in the field where I come from, it is two drastically different things.

I can relate an experience I had this last week in reference to field personnel. When we were addressing the Indian child welfare situation they did not even know that we were sharing this with them. There was a very clear indication to the representation of the 37 tribes here last week that the left hand did know what the right hand was doing from the standpoint of the Bureau of Indian Affairs. They honestly believe up here—I have to think that they honestly believe, because they are saying these things—that they are doing these things when in essence they are not. You get out there where I live and it is not happening.

I really think to some degree, and from what I heard the Congressmen here saying as well as the tribal representatives here, that all we are looking for is some cooperation. A lot of this could probably be resolved if we had proper cooperation and everybody knew what was going on. This was brought out earlier by the Congressman that left. He cited that very clearly. It is obvious that he has differences of understandings based upon what his Indian constituents are telling him versus what the administration is saying.

So I have to side with Mr. de Lugo. He only has to look at these people when he comes in here; we have to look at them every day; and we have to handle that kind of stuff every day, especially when you start wrestling with grand analysis and these kind of confusing things. The end result is nothing. That is just the way it is.

I think what we are asking for here is some cooperation. As stated in our testimony for the 37 tribes and the three states area, we are appalled, as Mr. McCain was, with the position that we have to presume on behalf of the administration, that the BIA and the Indian Health Service has taken. We just can't absorb it.

Mr. UNGER. Earlier this summer one of our staff members met with a young Sioux girl at the Devils Lake Reservation, 14 years old, in a youth program there. Her ambition in life is to live to be 16 years old. There are regrettably far too many Indian youth in that situation.

To be responsive to Mr. de Lugo and your question, the main thing I would try to remember is that all these great abstractions called Federal Indian policy are transmitted and reflect themselves in the lives of individual human beings and that decisions taken here by the people from BIA and IHS have actual effects, and those effects, for the most part, for two centuries have been devastating.

To try to be responsive to your specific question, my perspective is a bit different because the Association on American Indian Affairs is made up of members throughout the country who are Indian and non-Indian and whose basic concern is that Indian tribes be given just treatment by the Federal Government. I think from that perspective the single most radical departure that this Committee and the Congress as a whole could make is to insist and hold accountable the BIA, IHS, Department of the Interior, and all other Federal Agencies rendering services to American Indian tribes, to hold them accountable to the law that already exist, to the directive from Congress that already exist, because these are, after all, what tribes and attorneys speak about in terms of the trust responsibility.

These are the directives that Congress has made from the direction that Congress receives from the American people. It is responsive to what the average American of good will would like to see. I would personally look forward to the time when that happens, because, for one thing, it would mean that our organization could go out of business, because in a sense it is tragic that there is a need for an organization like this.

Mr. RICHARDSON. Do you have anything to add?

Mr. TROPE. I have nothing to add to what Mr. Unger has said.

Mr. RICHARDSON. Thank you.

The hearing is adjourned.

[Whereupon at 12:50 p.m. the subcommittee was adjourned.]

INDIAN JUVENILE ALCOHOLISM AND DRUG ABUSE PREVENTION

TUESDAY, APRIL 29, 1986

HOUSE OF REPRESENTATIVES,
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS,
Washington, DC.

The committee met, pursuant to call, at 10 a.m., in room 2167, Rayburn House Office Building, Hon. Morris K. Udall (chairman of the committee) presiding.

The CHAIRMAN. The committee will be in order.

Today the Interior Committee is holding its fifth and final hearing on the bills, H.R. 1156 and 2624, which would establish a comprehensive program in the area of Indian juvenile alcohol and drug abuse prevention.

I want to begin by expressing my appreciation to Congressman Daschle for his sponsorship of H.R. 1156. I would also like to commend Congressman McCain who is with us today for his sponsorship of a similar bill, H.R. 2624. They and the other co-sponsors of this legislation should be highly commended for addressing one of the most critical problems existing on many Indian reservations. Alcohol and drug abuse on reservations impacts most severely on our young Indian people. These young people represent the future of the Indian tribe. The lives of Indian youths who are the future of the Indian tribes will be impaired unless the U.S. Government shoulders its responsibility and seriously addresses this problem.

I want to assure you, those of you here today, that we are serious about enacting this legislation and seeing it is effectively implemented by the administration. The witnesses scheduled for the hearing today are young Indian students from all parts of our country who are here in the District of Columbia to attend a national Indian youth conference. They will tell us what their views are on the problems of alcohol and drug abuse. They will also comment on the bills and our efforts to address those bills.

I would like to welcome all of you young people here today, and say how pleased I am and the members are to have all you testify. This is an extremely important and momentous occasion for us to hear directly from the young people who will be most affected by the actions of Congress.

Because of the limited time available, we will only be hearing from 11 students and their oral testimony will be limited to no more than 5 minutes. For each designated witness, we will see two other students who will be from other regions in order to recognize them for the hearing record. If these other students have any prepared statements, they may submit them to the committee for the hearing record.

Before we begin, I would like to present the ranking Republican on the Republican Task Force on Indian Matters who has been most interested and helpful in this problem, Congressman McCain of Arizona.

Mr. **McCain**. Thank you very much, Mr. Chairman.

I would like to express my appreciation on behalf of many Americans for your continued efforts on this very difficult issue, which we are going to hear from so many young men and women today about.

I will not elaborate on your remarks, Mr. Chairman, because I think you pretty well covered the subject except to say that it is not an exaggeration to state that we are in a crisis situation among young Indians on our reservations. I recently received a letter from the chairman of the Fort McDowell Reservation who told me that as many as 50 percent of the young men on his reservation have fallen victim to Lysol, glue, paint and other substance abuse. I do believe that is a breach of the goal which we seek and which is for all Americans to be able to take part in a free enterprise system in this country. On our reservations our young Indians are plagued with this terrible curse of alcohol and substance abuse.

I appreciate your commitment. We will have a piece of legislation passed in this Congress in order to try and attack this terrible issue, and I am very appreciative of the holding of this hearing today. I think there is no better way of graphically demonstrating the extent of this problem than to hear from the witnesses that we are about to hear from.

Thank you, Mr. Chairman.

The **Chairman**. Our first witness is Terry Kitcheyan, San Carlos Apache student, accompanied by Annie Carlin, Papago student, and Mr. Lucian Garcia, White Mountain Apache student.

Terry, come forward and take the witness chair. You can bring your two companions, Annie and Lucian. We are very pleased to have you here in Washington, particularly someone from my own part of the country, the Apache reservations. You may proceed.

[Prepared statement of Terry Kitcheyan may be found in appendix II.]

STATEMENT OF TERRY KITCHEYAN, SAN CARLOS APACHE STUDENT, ACCOMPANIED BY ANNIE CARLIN, PAPAGO STUDENT, AND LUCIAN GARCIA, WHITE MOUNTAIN APACHE STUDENT

Mr. **Kitcheyan**. My name is Terry Kitcheyan. I am 17 years old and from the San Carlos Apache tribe. I am a senior at Globe High School.

Good morning, Mr. Chairman and committee members. My testimony has been prepared with the assistance of the Inter-Tribal Council of Arizona. We represent the Arizona tribes and are here to testify on behalf of the 19 tribes and communities: Ak-Chin Indian Community, Camp Verde Yavapai-Apache Indian Community, Cocopah Tribe, Colorado River Indian Tribes, Fort McDowell Indian Community, Fort Mojave Tribe, Gila River Indian Community, Havasupai Tribe, Hopi Tribe, Hualapai Tribe, Kaibab-Paiute

Tribe, Papago Tribe, Pascua Yaqui Tribe, Quechan Tribe, Salt River Pima-Maricopa Indian Community, San Carlos Apache Tribe, Tonto Apache Tribe at Payson, White Mountain Apache Tribe and Yavapai-Prescott Indian Community.

The State of Arizona contains 20 Indian reservations, the 19 previously named and the Navajo Nation with reservation lands totaling approximately 20 million acres which represents about 27 percent of the land base of Arizona. Arizona reservation population is approximately 167,000 persons of which 46 percent are 16 years of age or younger. Arizona reservations account for 40 percent of the national Indian reservation population and approximately 46 percent of the total reservation land base.

Arizona tribal leadership are concerned about the well-being of their young people. Through the integration of several resources, tribes are developing programs to meet the needs of their tribal youth. The Indian Juvenile Alcohol and Drug Abuse Prevention Act, if passed with the recommended changes, would expand and coordinate existing alcohol and drug prevention services for juveniles.

Arizona tribal leadership support the intent of the proposed legislation and raise several issues to strengthen its provisions and implementation.

TITLE I, COORDINATION

Title I of the Act requires Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) to enter into agreements to coordinate drug and alcohol abuse programs. The agreements would identify available resources for Indian people, define the roles of each organizational agency and unit with IHS and BIA in coordinating services and determine the extent of drug and alcohol problems among Indian children. The agreements would be reviewed every 6 months. Tribes are to be consulted in the development of the agreements and may also request agreements be made at the local level that will include definition of referral systems.

Comments I would like to present on Title I, Coordination.

Section 101(a)(3). The responsibilities of BIA and IHS in coordinating alcohol and drug abuse need to be outlined, but no funds for this effort is provided by new appropriations. How will work be funded through the current budgets?

Section 102(b)(2). Modifying the agreements between IHS and BIA semi-annually does not seem to be realistic and would be costly. This should be changed to "be modified bi-annually . . .".

TITLE II, EDUCATION

Title II requires that counselors working in programs funded by the Indian Elementary and Secondary School Assistance Act receive training in substance abuse counseling and that 10 percent of the fellowships awarded under the Indian Education Act be given to people who specialize in substance abuse guidance counseling. The Adult Education Act would also be amended to include provision of substance abuse counseling.

Substance abuse education in grades K–12 at BIA and contracted schools is mandated by title II. Some BIA schools would be required to remain open during summer months to provide recreation and counseling services for Indian children. BIA is also mandated to publish a quarterly newsletter about the programs funded under the act.

Title II, Education.

Substance abuse education in grades K-12 should be a priority activity, including the development of appropriate instructional materials. The publication and dissemination of a newsletter should be funded by alternate resources. Sections 204 and 205 should be changed to include, "services developed under this section shall be coordinated with existing local programs."

TITLE III, FAMILY AND SOCIAL SERVICES

Title III of the Act concerns training for service providers. Community health representatives would be required to receive one week of substance abuse training. IHS would be mandated to provide training in substance abuse, including crisis intervention and family relations to BIA and IHS personnel, to school boards, parent advisory committees, child protection teams and others upon request.

Comments, Title III, Family Services, Section 301.

It is our understanding that community health representatives and other IHS personnel already have alcoholism training available. Further, we understand that IHS and BIA have existing training dollars which can be utilized by IHS and BIA staff. Training for adults should be targeted for those persons identified in 301(b)(2) and should be ongoing local reservation-based training. The benefits of training for BIA and IHS staff and other adults should not be a priority over direct services and preventive education for juveniles. We suggest the language at 301(b)(1) be changed to read "The Director of the Indian Health Service may provide training . . .". Section 301(b)(2) should include employees of tribal programs in the human services.

TITLE IV, LAW ENFORCEMENT

Under title IV of the legislation, BIA police would be trained on the substance abuse problems of Indian children. Tribal, BIA and federal law enforcement personnel would be required to detain children who are arrested for alcohol or drug offenses in shelter facilities, foster homes or community treatment facilities. State law enforcement personnel in Public Law 83-280 states would be "urged" to comply with this mandate. Shelter homes would be paid by the BIA and approved by the tribes.

Comment, Title IV, Law Enforcement:

Section 402(a)(1). One problem with this section is that some tribes have juvenile codes which establish the procedures for handling juveniles arrested for alcohol and drug offenses. Those often include release to parents. The proposed legislation is too restrictive in that it requires shelter placement and would seem to supersede tribal codes and parental involvement. The other concern is that shelter placement may not be the best option for a youngster involved in serious drug trafficking or for one who is violent. We recommend language at 402(a)(1) line 6 be changed to read

". . . drugs or alcohol shall, when appropriate, detain such juvenile in a temporary emergency center . . .".

TITLE V, TREATMENT AND REHABILITATION OF CHILDREN

The Director of IHS is mandated under title V to research the need for, the cost of and the appropriate location of substance abuse residential treatment facilities for Indian children. IHS hospitals would be required to provide comprehensive alcohol and drug services, including detoxification and counseling, and IHS would have authority to build regional substance abuse treatment centers for youths.

Comments, Title V, Treatment and Rehabilitation of Children:

Section 502. No funds are authorized for this title. The IHS alcoholism services are currently underfunded. What mechanism will be used to assure comprehensive alcohol and drug treatment facilities and the construction of new facilities when no new funding is available?

TITLE VI, DEFINITIONS, EFFECTIVE DATE AND AUTHORIZATION OF APPROPRIATIONS

Title VI provides definitions to terms used in the proposed legislation and authorizes an appropriation of $5 million.

Comments:

Section 603. We do not believe that $5 million is a large enough sum to carry out all of the work specified by title II, III and IV. We recommend that $30 million be authorized to carry out all the provisions in all titles of the legislation.

The CHAIRMAN. Does that complete your statement, Terry?

Mr. KITCHEYAN. Yes.

The CHAIRMAN. You go to Globe High School?

Mr. KITCHEYAN. Yes.

The CHAIRMAN. Your home is where?

Mr. KITCHEYAN. San Carlos, Arizona.

The CHAIRMAN. How many students are enrolled in your high school?

Mr. KITCHEYAN. I would say around 500.

The CHAIRMAN. How many of those are Apache?

Mr. KITCHEYAN. Three-fourths.

The CHAIRMAN. Three-fourths of the student body?

Mr. KITCHEYAN. Yes.

The CHAIRMAN. How far is it from San Carlos to Globe High School?

Mr. KITCHEYAN. Eighteen miles.

The CHAIRMAN. Do you take the bus every day?

Mr. KITCHEYAN. Yes, sir.

The CHAIRMAN. Of the students at Globe High School, how many would you say from your own personal knowledge use alcohol occasionally or frequently?

Mr. KITCHEYAN. Seventy percent.

The CHAIRMAN. Seventy percent?

Mr. KITCHEYAN. Yes, sir.

The CHAIRMAN. Is alcohol use higher among Indians than non-Indians?

Mr. KITCHEYAN. Both.

The CHAIRMAN. Lower?

Mr. KITCHEYAN. Yes.

The CHAIRMAN. If there is one thing you had to tell us here about this program, what would you have to say? There is a real need for it?

Mr. KITCHEYAN. Well, I would say that this should be passed because it is really needed in the reservations. It is not right for Globe students or students from the reservations of any kind to be drinking alcohol. It is——

The CHAIRMAN. If you got a problem with alcohol now as a student at Globe High School, where do you go? Is there any place you go for help?

Mr. KITCHEYAN. Excuse me.

The CHAIRMAN. If you had a problem with alcohol and you were a student at Globe High School, where could you go for help? Are there doctors, clinics, facilities of any kind either at home or down at school? You have no facility?

Mr. KITCHEYAN. If there were a program I would go there. It would be a lot of help.

The CHAIRMAN. You want to introduce the two people with you at the table.

Mr. Garcia.

Mr. GARCIA. Yes, sir.

The CHAIRMAN. You are White Mountain?

Mr. GARCIA. Yes, sir.

The CHAIRMAN. Where do you go to school?

Mr. GARCIA. I go to school at the high school on the White Mountain Apache Reservation in Arizona.

The CHAIRMAN. How big a high school is that?

Mr. GARCIA. Well, we have 500 students and 70 percent of them are Indians.

The CHAIRMAN. How many students at your high school have used drugs or alcohol?

Mr. GARCIA. At least 60 percent, sir.

The CHAIRMAN. Is it getting better or getting worse?

Mr. GARCIA. It is getting worse. It will be—almost every month it increases by 1 percent.

The CHAIRMAN. And you are Annie Carlin.

Ms. CARLIN. Yes.

The CHAIRMAN. Where is your school?

Ms. CARLIN. I go to the school on the Papago Reservation. There are about 200 to 300 students there.

The CHAIRMAN. Mr. McCain.

Mr. MCCAIN. Thank you, Mr. Chairman.

For all three you mentioned, Terry, it is about 70 percent of the students with alcohol or drug abuse in your high school.

Mr. KITCHEYAN. Yes.

Mr. MCCAIN. Mr. Garcia, you mentioned 60 percent and, Annie, what is the percentage at your high school? Would you estimate?

Ms. CARLIN. I would say about 80 percent.

Mr. MCCAIN. About 80 percent. What percentage do you think are constant users? First you, Terry, as opposed to occasional experimentation?

Mr. KITCHEYAN. I would say about 70.

Mr. GARCIA. At least 50.

Ms. CARLIN. About 70.

Mr. McCAIN. Is it easy to obtain alcohol for students?

Mr. KITCHEYAN. No.

Mr. GARCIA. Yes. We have a lot of bootleggers up around that live there that sell illegally, and there is a lot of students who get away with buying, obtaining liquor from the liquor store without an ID.

Ms. CARLIN. Yes, on the reservation they have bootleggers and all over the place, and it is very easy for students to get it out there.

Mr. McCAIN. How easy is it to obtain drugs?

Terry, you first.

Mr. KITCHEYAN. I think it is very easy.

Mr. McCAIN. What kinds of drugs?

Mr. KITCHEYAN. Marijuana.

Mr. McCAIN. Mainly?

Mr. KITCHEYAN. Yes.

Mr. McCAIN. What about the use of substances: glue, paint, Lysol?

Mr. KITCHEYAN. No.

Mr. GARCIA. The drug that people use in our school is mainly marijuana and they usually grow it around their home, and the glue is mainly used in the lower grades, like junior high and elementary.

Mr. McCAIN. Glue is used in elementary school?

Mr. GARCIA. Yes.

Ms. CARLIN. It is easy to get marijuana over there. There is a lot of students that even take cocaine and stuff like that. A lot of times they can get glue or whiteout and stuff from school; they will take it from school, and they can get paint at the store.

Mr. McCAIN. We heard Terry's recommendations. Do you all have any additional recommendations or comments?

First you, Mr. Garcia.

Mr. GARCIA. No comment.

Ms. CARLIN. I think what we want to say is these are good steps and they should be passed.

Mr. McCAIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Kildee.

Mr. KILDEE. I have no questions at this time.

The CHAIRMAN. Thank you very much. That completes your testimony.

Now, Ms. Rhoda Tso, Leonard Begay, and Celeste Toglena.

Before you begin, let me say to you and to the other young people that are here today, the purpose of this hearing is to give us, the members of Congress, a feeling for this problem, an idea of what to do to help, an idea of what you might suggest. You know more than any of us in the room about the problem of alcohol and drug abuse on the Indian reservations, and we need your help.

We have a limited amount of time, as you can imagine. If you've prepared a written statement, we will make it a part of the permanent record. We will print a book which you will get a copy of later on with all the testimony in it. The best use of your time would be to give us that statement, leave it for the record and tell us in your own words in 3 or 4 minutes, what we ought to know, how bad the problem is, what works in helping in this problem, what does not, and then answer the questions that the members might have.

Let me encourage all of you to take 3 or 4 minutes and, where you can, summarize what you think you would like to have us hear. If you cannot summarize, you might want to read what you feel are the most important parts of your statement.

With that, Rhoda, you want to lead off here.

Ms. Tso. I guess so.

The CHAIRMAN. I will be back from time to time. I have to leave for a while. Mr. Kildee is going to chair. I did not mean to intimidate you if you would rather read.

Ms. Tso. I would rather read the prepared statement.

The CHAIRMAN. Let me urge you and the other witnesses that this is your chance to talk to several Congressmen who will be writing the law and, rather than read a statement someone else may have prepared, it would be better to just tell us in your own words what you think we ought to be doing with these problems. Some of you worked very hard to prepare yourselves for the hearing, and I do not want to stop you from reading at least part of your statement. Go ahead.

Mr. KILDEE [presiding]. I would like to indicate that in real life I was a school teacher, so if you have good feelings towards your school teachers, you can have good feelings toward me. If you do not, indulge me anyway. I taught high school and I learned a great deal from my students while I taught, and that is why we have you here today, because you can teach us a great deal about this problem.

Rhoda, you may begin your statement.

[Prepared statement of Rhoda Tso may be found in appendix II.]

PANEL CONSISTING OF RHODA TSO, NAVAJO STUDENT FROM PAGE, AZ, ACCOMPANIED BY LEONARD BEGAY, NAVAJO STUDENT FROM TUBA CITY, AZ, AND CELESTE TOGLENA, NAVAJO STUDENT FROM SHIPROCK, NM

Ms. Tso. Mr. Chairman and members of the committee.

On behalf of the Navajo students at Page High School and as members of the Page High School Intercultural Club, we would like to take this opportunity to thank you for allowing us to express our concerns toward H.R. 1156, "Indian Youth Alcohol and Drug Abuse Prevention Act."

In our testimony, we will clarify our situation regarding alcohol and drug abuse among Native Americans in our area and the views we have of the bill itself.

Page High School is basically made up of two ethnic/racial groups, Anglo and Navajo; each approximately 50 percent of the slightly more than 800 student body total.

In order to get a general idea of the status of students in our area, we took a poll among 103 senior students. We found that of the 63 Native Americans we polled 41 percent said they do use alcohol. Sixteen percent admit to having abused alcohol at one time or another. Of the same group, 24 percent claim to use drugs while 14 percent said they have abused drugs.

In our poll, we asked all 103 students (mixed group) how they would rate the alcohol and drug problems at Page High School on a scale of 1 to 5 (5 being the most severe). The alcohol problem averaged the rating of 3.0 while the drug problem rated slightly lower with the average of 2.6.

Finally, we asked students when they had first experimented with drugs or alcohol. Excluding those who have never tried them, Native Americans averaged 14.8 years of age as the first time they drank alcohol; with drugs, they averaged 15.2 years of age. According to the poll, some students tried alcohol and drugs as early as 7 or 8 years of age.

From the information we gathered, we can conclude that our area has been stung by this epidemic similar to the pattern of the rest of the Native Americans. It is sad to know that many of our Indians are already trapped within the cycle they want so desperately to escape.

We agree that if we are to overcome this frightening situation we must treat alcohol and drug abuse like any other serious disease. The same principles can be applied. First, we must treat those who are very ill. Next, we must stop those who are in present danger. The most important, we must educate the coming generation. If students are starting to experiment at age seven, programs taught by well-trained persons need to start early when they are in preschool and in kindergarten. We are especially pleased to see that you have included such programs in this bill.

We all realize alcohol and drug abuse is a problem that needs to be dealt with; however, we need to be concerned with problems that have resulted from these abuses as well. The problem we have in mind is suicide. Suicide is the second leading cause of death among Native Americans. Alcohol plays a factor in 75 to 80 percent of them. We feel that this bill could be improved by adding programs to help prevent more Indians from taking their lives. We hope the discussion of this bill in Washington will give us some concrete suggestions addressing this need.

Before we thought we could make any statement upon receipt of this information and copy of bill 1156, we wanted to know what the local situation was and what was being done. So I polled 103 seniors. I interviewed our assistant principal and counselors about the youth alcohol program and the trends seen over the past few years. I also interviewed our local social services representatives for further data about social service organizations attacking this problem and giving family assistance available in our area. I checked with law enforcement to see what services they are providing.

Our conclusions are, one, there are avenues already attacking this national problem. Therefore, the bill, 1156, is correct in coordinating and expanding services but should not add another administrative level and its expenses through these funds. Through this bill, guidance and publicity through the proposed newsletter can be shared as to what is available or will be available and providing an avenue for sharing pertinent information on a national basis.

No. 2, we support the expenditures for training adults and also suggest more peer counselors for every age level and support the improvement of family services as needed. Individual contact and support seems very pertinent to the success of rehabilitation work, prevention programs and motivational programs.

No. 3, parental involvement is to be encouraged and we have only begun to identify this area. As economic levels improve, as intercultural understandings are cultivated, parents can take a more active position in communications with their children and improve their understanding of the world the children face, encourage educational motivation of their children and interact more effectively with their children in choosing good alternative behaviors from the many avenues bombarding young people today, thus giving more value clarification and encouragement of more critical selectivity on the children's part.

Finally, No. 4, "masculinity," "femininity" and "family" concepts need clarification, cultivation and appreciation from adults and children in order to engender a mutual support system and improve our future. The greatness of this nation has always been evident in the growth of social, physical, mental and spiritual commitment of our people. The elevation of manhood and womanhood and reaffirmation of the importance of a strong nondenominational spiritual commitment on the part of individuals will do much to offset the extremely materialistic trends seen today.

Thank you.

Mr. **Kildee**. Thank you very much, Rhoda.

I noted in your testimony that you gave us what should be done, but also you addressed yourself to the why of the problem. I think that is very important. I have three teenage children, and so far they are not involved in drugs, for which I thank God very, very much; but it is a problem that cuts across America. It is a problem that we have to address as a Nation, and there are certain areas where perhaps the problem is more acute.

Do you think that if we were to give our young people, and our young people in this case particularly in the Indian nations and tribes, a greater hope for the future through greater hope for education, greater hope for jobs, that that might lessen their attraction to the use of drugs?

Ms. Tso. Yes.

Mr. **Kildee**. Do you think that along with that we should address ourselves to the causes of using drugs as an escape. Why I ask, Rhoda, is when the Indian Nations gave up vast tracts of land, millions and millions of acres, very often very unwillingly, the one thing that the U.S. Government promised—and while you are here in Washington you might want to go down to the National Archives and look at the treaties which the United States signed with the Indian Nations—the one thing we promised universally was education for the Indians and Native Americans of this country, and I do not think really we have done that good of a job in delivering upon that treaty obligation. I think we have a moral, legal and treaty obligation to the Indian Nations and tribes of this Nation.

So do you think if we were to give greater hope for education and that education could lead to some meaningful employment that that, again, would lessen that attraction of drugs?

Ms. Tso. Yes. Yes, in many aspects, yes.

Mr. Kildee. Leonard, do you have any comment on that?

Mr. Begay. I have a little testimony here which I would like to read if I can.

Mr. Kildee. Sure, go ahead.

Mr. Begay. Mr. Chairman and members of the committee, my name is Leonard Begay, and I am a student body president of the Tuba City High School which is located on the Navajo Reservation. I am pleased to have this opportunity to present my views on the proposed Indian Juvenile Drug Prevention Act.

I am in favor of the bill but with certain modifications. Mr. Chairman, the need for this bill cannot be underemphasized. As, in fact, stated the high school dropout rate, the incidence of alcohol and drugs among the San Carlos Indians, among my colleagues, are increasing at an alarming rate. In my opinion the reasons for these trends are the loss of self-esteem, attributed to forced alienation from traditional culture and economic opportunity. Collectively these factors lead to beer, alcohol and substance abuse.

I am a student council president of one of the largest Indian high schools on the Navajo-Hopi Reservation and one of the largest in the Nation. Yet I am not aware of any programs dealing with alcohol or substance abuse prevention and treatment in our school system.

Mr. Chairman, I do not understand why this administration opposed this bill on the ground that programs already exist to address these problems. Part-time counselors, 1-hour presentations and special guest lectures are simply inadequate to address the many complex problems that are needed in the treatment of these abuses. What we need in our opinion are culturally relevant programs emphasizing treatment as well as prevention which are available to all ages. By that I mean programs that insist on improving individual self-esteem, by drawing on the strengths of the traditional welfare and emphasizing healthy behavior and community participation.

Mr. Chairman, the bill does not call for the integration of cultural programs, and I believe it should. We encourage support for the bill and prompt action.

Thank you.

Mr. Kildee. Thank you very much, Leonard.

Celeste, you want to respond to my question, maybe my comment, on what we can do to better carry out our obligation to help the Indian Nations in this country to provide education and hope for our Indian Nations and tribes, and also in conjunction with what Leonard said, to help stop perhaps an alienation from traditional cultural ties. I think that is very important. Very often, you have a sovereignty under the treaties of this country and that sovereignty is given so you have your culture. I have lived around the world. Cultures can be different. One is not superior or inferior to the other.

I think, Leonard, you made a very good point. This alienation from your traditional cultural ties is one of the causes of this problem here.

Celeste, would you like to comment on my question on education or alienation which Leonard mentioned?

Ms. TOGLENA. Yes, we have ideas about open recreation during the summer for the youths so they have an option between the drugs and the recreation which we think most of the youth in the area would choose the recreation over the drugs. There is 700 students who attend Shiprock High School, and of that 80 percent have used drugs and alcohol and 95 percent use drugs and alcohol regularly.

The drug problem at Shiprock High School is very severe and recreation would be very good for the youth at Shiprock.

Mr. KILDEE. Thank you very much, Celeste.

Mr. McCain.

Mr. MCCAIN. Thank you all for being here this morning.

Leonard, you mentioned that there is no program that you know of at your high school concerning drug and alcohol abuse. Is that correct?

Mr. BEGAY. Yes, that is correct.

Mr. MCCAIN. Rhoda and Celeste, would you comment. Are there programs at your high schools?

Ms. TSO. There is a program at my high school, youth alcohol program.

Mr. MCCAIN. Would you comment on its effectiveness.

Ms. TSO. I talked to the social worker who directs this, and it seems to be very effective. Well, what happens is the procedure is if a person is caught with drugs or something on the school campus they are taken to these programs and they sit in seminars, I guess you would say, and they lecture to these students and inform them, which I think is very important. I think there is a lack of knowledge among Indian Americans.

Mr. MCCAIN. Celeste.

Ms. TOGLENA. No, sir, we do not have any shops for these students to go to.

Mr. MCCAIN. Celeste, at your high school what would happen if a student were found to be high either on alcohol or drugs by the teacher?

Ms. TOGLENA. That happens every day at school. That is nothing new.

Mr. MCCAIN. What happens? Is the student sent home or suspended?

Ms. TOGLENA. They are suspended from school. A parental conference is called; and if that does not help, then the student is just taken down to the jail.

Mr. MCCAIN. What needs to be done to help to address the problem? Starting with you, Leonard.

Mr. BEGAY. Well, I think we should be concerned with the treatment of people who are now addicted and I think we should start a program that deals with the prevention of alcoholism.

Mr. MCCAIN. Rhoda.

Ms. TSO. I cannot really give you any answers. Like many of us, I do not know. But I think a combination of many factors would really help, like improve, help them get an education, inform them on alcohol and drugs, because I spoke to Mr. Perry Pulas who is a counselor at the youth alcohol program, and he pointed out that in the Native American language, Navajo, there is no word for social drinking, and he pointed out that how could—there is just a word for drunkard. That is the only name for it, and there is a lack of knowledge. And he said that how can people know if there is not any word for it. And I think it is just—they do not know how. They do not know how to control themselves. It is like——

Mr. McCAIN. Do you feel that the fact that most young men and women feel that there is not much chance to get a job after they graduate has an effect on increasing the alcohol and drug abuse, lack of job opportunities?

Ms. TSO. Yes, I think so. I think they feel that they cannot make it in a world, a white man's world. I think they feel real alienated and two separate worlds, and they just clash in many cases. I feel that Native American parents see all their lives they have been, you know, livestock raisers and they never knew the importance of a good education. It is never really stressed in the homes. It is apparent among a few Native Americans I know that have never attended school and they herd sheep during the day, and the parents do not stress education toward them, so they do not feel it is very important. That is why they do lack job opportunities because they do not have the education and do not have the parent support behind you. I think it is really important.

Mr. McCAIN. Thank you.

Celeste.

Ms. TOGLENA. I think they should be concerned about how the person feels who is using the drugs and get communication between the youth and the parent which could be a problem of the youth turning to the drugs, lack of communication between the kids and the parent.

Mr. McCAIN. Thank you.

Thank you, Mr. Chairman.

Mr. KILDEE. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. Thank you for holding these hearings and certainly to the witnesses for appearing here today.

Earlier this year I had an opportunity with the Select Committee on Children and Families to tour a number of reservations in the West. We spent an awful lot of time talking to young people on different reservations, and one of the things that just continued to show up was the lack of recreational resources on the reservation, whether we were on the Navajo or the Papago, or up in the Yakima. Young people testified over and over again that there is simply nothing to do, so young people just hang out and eventually they get into trouble, eventually they start drinking and eventually they start taking drugs, and that is just the fact of it. And what we did see was an example from, Southern Utes drug busters program in southern Colorado where young people were given an opportunity to develop this resource for themselves, create a teen center, to create something like drug busters, and they seemed to be testifying that those were very positive activities; that when young people had an opportunity to create drug free dances or events or fun runs or these kinds of educational opportunities, in fact, the teenages participated in them. At the Laguna-Acoma Pueblo in New Mexico they tried it first by setting up a health center; the State set up a health center for the entire community and the teens wouldn't go, and later the young people got an opportunity to run their own clinic right on the school site, and now it is almost the center of most activities on the reservation. I think at least the young people there feel it even led to some decline in the amount of drunk driving taking place. They had a very severe tragedy, I think it was a senior-junior prom or senior ball, the year before where a number of students were killed.

And it seems to me that a valid criticism when you look around the reservation in terms of lack of activities to stimulate young people; that an awful lot of people went great distances on the bus to go to school. By the time they got home, there was not a lot of time left and boredom was a very, very serious problem. But the flip side of that seemed to be that the teenagers were willing to deal with the problems if they had some resources.

We went out to Klagetoh on the Navajo Reservation. There were no resources. Nothing. Not something. There was nothing except to play in the street as some of the younger people were doing, which was just simply playing hopscotch. That was—except on Monday nights I think the church had a video and they could watch a movie.

So it seems to me you start to understand what can take place when you have young people in any community where there is just no outlet for the energies and the creativity and the initiatives of young people. I just wondered if you think legislation like this ought to accompany some efforts to provide community resources in terms of teen centers, activities for the very constituency we are trying to help here, but we are coming in kind of at the end instead of working in some efforts towards prevention. I do not know if that makes any sense to you or not. Do you think that would be helpful?

Ms. Tso. Like I said before, we are going to have to hit a lot of aspects of this problem, hit a lot of bases, and I think this is one. I think kids do need something to do on the reservation, and in our area all we have is one set of basketball courts and that is it, where I am from.

Mr. Miller. Klagetoh is where you had a standard, but they do not have a backboard for the standard, no hoops. Great court but no hoops.

Anybody else?

Ms. Toglena. We could have the schools open during the summer, public schools open and we could have recreation there. We were thinking of asking the people who run the public school, but we have not really had time to do it. They do not want to talk to us about it.

Mr. Miller. To use them as a community center, teen center during the summer?

Ms. Toglena. We would like it to be open, but they just do not want to talk to us about opening the school because of the way it is built. It is a new school.

Mr. Miller. I would hope when we look at this legislation we would really keep in mind, I think, most of the successful programs that I was able to witness have had very, very extensive involvement by the young people. There was no shortage, I think, of concern by the young people on the reservations and there was no shortage of ideas; but there was a tremendous shortage of resources to get those things done. I would just hope that if we write this legislation we would make sure that the young people are involved and that, in fact, it is a program that they help to design. Because I think, even in my own district, we are finding out when you are dealing with the problems of drugs, alcohol, teenage pregnancy the greater involvement we have of young people the more successful the program is. They start to adopt it as their own and support it and make an effort to make it work, and I just hope we would not in this one have a lot of other people looking out after your interests as opposed to encouraging young people looking out after their own interests.

Thank you very much.

Mr. **Kildee**. Mr. Cheney.

Mr. **Cheney**. Thank you very much, Mr. Chairman.

I wonder if I might ask our witnesses who testified this morning about a couple of concerns I have, and I would find it useful if you have information you would care to contribute. Obviously, the problem of drug abuse and alcohol abuse and suicides is widespread throughout our society. Right here in the District of Columbia, in the white collar suburbs in Fairfax and Montgomery Counties, some of the wealthiest communities in America, we face similar problems in terms of alcohol abuse, drug abuse and suicides among teenagers. If you have evidence this morning or information you care to present that talks about the differences, how the situation differs with respect to the reservation or compares to other segments of the society, I would find that useful, if people would volunteer or make comments about it.

I would also be interested if we have any success stories; that is, are there programs in operation on Indian reservations that are especially effective or that demonstrate results, where we have been able to fundamentally change or alter the destructive pattern of behavior we see?

And I would like to thank you all for being here this morning.

I yield back, Mr. Chairman.

Mr. **Kildee**. Mr. Daschle from South Dakota. Mr. Daschle, do you have any questions of our witnesses?

Mr. **Daschle**. Thank you, Mr. Chairman.

I am very grateful to you and the committee for giving me an opportunity to sit in on this hearing. I commend the witnesses. We have a lot of opportunities to listen to people throughout the day. I just came from another committee, and the three of you have in the most articulate manner voiced the concern and given us a tremendous insight and I am grateful for that. I know that the rest of the members are too.

I apologize for being late, but if you could very briefly summarize what you think would be the one or two most important things we could do as a committee. You probably addressed a myriad of different issues, and you said already there are a number of factors; but for my interest, if you could prioritize the top two, I will be very grateful.

Ms. **Tso**. I think one of the main factors is the family. In my last paragraph I said that we got to work on the whole family, not just the person who is sick themselves. I think that is one of the areas we really need to concentrate on and really build up the family;

and if we can build economic security and give some intercultural understanding between cultures, parents would have more time to spend with their children and build a better communication between them.

Mr. **Daschle**. Your top two would be to ensure that there is more opportunity to build the strength of the family and, secondly, more communication perhaps between Indian and non-Indian people with regard to this issue in particular; is that what you are saying?

Ms. Tso. Yes.

Mr. **Begay**. I think that we should have more communication between the family and people in the Anglo world, but I think that the top priority is communication because in order to get something we need to communicate first to let them know what our problem is and, I think that when these programs do start, they should have a background of people they are dealing with, like their culture, and we should have special counselors and guest speakers and presentations to help these people and we should be concerned with prevention because that is where I think that we should start, because we should try to prevent this problem instead of dealing with it. People already have their problems; I think we should put top priority in preventing it.

Mr. **Daschle**. Thank you.

Ms. **Toglena**. Number one priority I think is for communication between the youth and the parent, because that is what they are lacking. The youth may sometimes feel that they are being neglected by their parents, and they just turn to drugs because they are there. That should be the number one priority.

The second one I think would be to have good recreational facilities for the youth and the parent so they are both involved and they know what the problem is about them, what they can do to help each other with the problem.

Mr. **Daschle**. So the essence of what you are saying is there has to be a better family relationship, more communication and a lot more work in ensuring prevention through recreation, opening the schools, those kind of things, counselors, as was said earlier; the prevention side of things have to be a lot more effectively demonstrated than we have seen in the past.

Ms. **Toglena**. Yes.

Mr. **Daschle**. Thank you all.

Mr. **Kildee**. Mr. de Lugo.

Mr. **de Lugo**. Thank you very much, Mr. Chairman.

From your observation, when a young person is in trouble with drugs or alcohol—of course, alcohol is a drug—what is the most effective way of reaching that young person, of helping? My understanding is that it is far more effective if the person that tries to reach the young person is in the same age bracket or is a young person too, and it is even more effective if that young person has had or has dealt with the problem of drugs or alcohol, you know, themselves. Would you comment on that.

Mr. **Begay**. Yes, I believe that would be the most effective way because most students would not feel comfortable speaking to somebody who is older than them and, to top that, who did not know how it feels to have a drug problem. I feel they would feel more comfortable speaking to somebody who has had the problem, who is the same age group as they are.

Mr. de Lugo. I think one of the most wrong approaches is to have an adult come in and lecture somebody about this. You just tune him right out. This is not a moral problem. It is not a problem you can lecture on. This is a problem with a lot of pain and agony, and I think the only person that you are going to listen to is somebody who you figure is leveling with you, that has gone through some of that pain and you can identify with.

Are there Alateen programs conducted? Is there an AA organization?

Mr. Kildee. Perhaps the radioactivity of the nuclear fallout from the Soviet Union is here. Someone has sent for the technician.

Mr. de Lugo. These are the other sides of Gramm-Rudman.

Mr. Kildee. We will try to proceed without the sound system until we get a technician here who knows more about it than I do. Teachers are limited in their knowledge, you see.

Mr. de Lugo, I know you have a booming voice, and you can be heard.

Mr. de Lugo. Thank you very much, Mr. Chairman.

I have been impressed by the success that Alcoholics Anonymous has had in the country, in all age groups, and from my observation Alcoholics Anonymous has been effective because it is people who have actually experienced the problem, and there are a lot of mistakes that we have made over the years, a lot of misconceptions we had about drugs and alcohol over the years. I know that at AA they teach a program of tough love and that is telling an alcoholic exactly what it is like and you got to get the help and the, of course, helping. They have an incredible success rate.

Is AA active on any of the reservations or in any of the Indian communities to your knowledge?

Mr. Begay. Yes, we do have AA, but it is not really a strong organization.

Mr. de Lugo. It is not strong.

Mr. Begay. It is not strong.

Mr. de Lugo. Is that more adult groups of AA or do you have Alateen?

Mr. Begay. It is more of an adult organization, and it is under the Public Health Service and we do not have anything at our school.

Mr. de Lugo. I see. I notice that there is one theme that you have all come back to and that is communication within the family and support within the family. You feel that lack of communication within the family is one of the things, lack of understanding is one of the things that leads to teenage alcoholism or drug use? That is a strong contributing factor?

Mr. Begay. Yes, I do.

Mr. de Lugo. You feel people really are not hearing what you are saying or really are not interested in what your concerns are?

Mr. Begay. Well, I think that students just are not used to communicating with their parents because some of their parents are working or they really do not have time to see them, and students are at school and it is during the daytime; and then their parents are at work, so they really do not see that much of each other.

Mr. de Lugo. Tell me——

Mr. Kildee. The Chair at this point—I hesitate to do this, but we are falling behind schedule a great deal. The Chair will try to adhere to what we call here in the Congress the 5-minute rule. So if the members could adhere to the 5-minute rule, the Chair would appreciate it. Go ahead.

Mr. de Lugo. I prefer to listen to the witnesses anyway. I will ask questions from time to time, but I want to thank you very much for coming here and testifying before the committee. This is the only way we will be able to help the committee to understand the problem. We only understand it from hearing from people who have dealt with it and have seen it in their communities.

Let me ask just one final question. You have friends who are in trouble with drugs or alcohol?

Mr. Begay. Yes, I do.

Ms. Tso. Yes.

Mr. de Lugo. If you were to pick out one thing, think of one friend that is in trouble with alcohol, drugs and it is hurting, tell me one thing—what do you think would be the most effective thing that there could be done to help that young person today?

Mr. Begay. I would have to say they would have to go see someone that did have a problem and that is in their same age group. I think that is the only way my friend could get help.

Mr. de Lugo. They would have to go see someone who had the problem, had the same problem.

Mr. Begay. Yes.

Mr. de Lugo. And talk to them and relate to them. Go ahead.

Mr. Begay. I think that is where they can start to help that person. Then later on you could have counselors, older people counseling them and tell them about the effects of alcohol and substance abuse, what it can do to them and their bodies. I do not think that anybody has a right to tell that person not to drink and not to take drugs because I do not think it is their right to make that decision for that person.

Mr. de Lugo. Thank you very much, Mr. Chairman.

Mr. Kildee. I will try to take them in the order they came in. The gentleman from Nebraska, Mr. Bereuter.

Mr. Bereuter. Thank you, Mr. Chairman.

I have a statement I would ask unanimous consent I might have it inserted in the record so I can save time.

Mr. Kildee. Without objection, your statement will be so entered.

[Editors note.—Prepared statement of Hon. Doug Bereuter may be found in appendix II.]

Mr. Bereuter. Thank you, Mr. Chairman, and thank you for permitting me to sit in with the Interior Committee today.

I am very pleased to say that the timing is excellent for the hearing today because we have four related amendments offered by the gentleman from South Dakota, Mr. Daschle, and myself which are part of the Indian Health Care Improvement Act and will be voted on by the full House shortly. I want to say to our panelists how honored and pleased I am to welcome you to the Indian UNITY conference here in Washington.

We do know that alcohol and drug abuse is the number one health problem and social problem on many of our Indian reservations today, I dare say perhaps all of them. Some Indian officials from the reservations have told us as much as 77 percent of their health care budgets are used on alcohol and drug-related services, and we have also been told by others that 90 percent or more of the accidents that occur on reservations are related to alcohol and drug abuse.

The whole thrust of the legislation offered by myself and the gentleman from South Dakota, and many others, and a bill offered by Mr. McCain on which I am an original cosponsor is aimed at the prevention, and the primary place that we are trying to start that prevention effort is not exclusively but primarily in the school system.

What are your thoughts, very candidly, about the school system as a place to begin at an early age in drug prevention programs? Will that be successful? What is your own experience? I know some you come from an area where you do have some drug prevention, alcohol use prevention programs in your schools. Others are not so fortunate. How important has that been and how long have you been proceeding with it?

Ms. Tso. We have no real problems like that, but I feel if we do start in the schools it would be much more effective than if we had counseling places. Students will listen to their peers more than their teachers. You got to admit that peer pressure is really strong, you know, in the school system. I feel if we can kind of reverse that peer pressure that is on them right now for pressure to drink, might reverse with a push not to drink, it might have some effect. You know, students do not want to listen to anybody telling them what to do; but if they have someone they feel cares, students their own age, I think that it would be very effective.

Mr. **Bereuter**. My children are being bombarded with an anti-smoking campaign from the beginning of their school, and it seems to me the peer pressure is working against smoking and I know that they are talking to their parents about it and they are concerned about the parents' health. Do you think that is an example that might work in drug abuse and alcohol abuse?

Ms. Tso. Absolutely.

Mr. **Bereuter**. Anyone else have anything to suggest in this area?

Thank you for your comment.

Thank you very much, Mr. Chairman.

Mr. **Kildee**. Thank you, Mr. Bereuter.

The gentleman from Oklahoma, Mr. Synar.

Mr. **Synar**. No questions.

Mr. **Kildee**. The gentleman from Washington, Mr. Lowry.

Mr. **Lowry**. No questions. Thank you for allowing me to stay.

Mr. **Kildee**. I want to thank the witnesses for your testimony. We are behind schedule, not because of you, but we ask a lot of questions up here.

Let me say this. I am going to be coming in and out because I have my own bill on the Floor today. I traveled out and visited many of your tribes and nations. If any of you wish to drop by my office after 2:30 today, if you are still in the area, my bill should be finished hopefully by that time. My office is right in this building, room 2432, the fourth floor. I will be glad to meet with you as a group or individually. I want to thank you for your testimony today. It has been very, very welcome.

The next panel consists of Stephanie Fox, Mandan-Hidatsa, Fort Berthold, North Dakota, accompanied by Ms. Renee Saunsoci, Omaha Tribe, Nebraska and Ms. Traci Rouillard, Lower Brule Sioux, South Dakota.

I am reminded by counsel that the procedure that we are trying to follow is that the lead witness will give the main testimony. The testimony of the other two witnesses will be submitted in its entirety for the printed record which you will receive a copy of, and we will ask questions of any and all of you at that time.

You may proceed. The technician is on his way, so we will try to get the microphones on. So shout as you would in a gymnasium. Speak up clearly because of the technical problems.

[Prepared statement of Stephanie Fox may be found in appendix II.]

STATEMENT OF STEPHANIE FOX, MANDAN-HIDATSA, FORT BERTHOLD, ND, ACCOMPANIED BY RENEE SAUNSOCI, OMAHA TRIBE, NE AND TRACI ROUILLARD, LOWER BRULE SIOUX, SD

Mr. KILDEE. I think what we are going to do, inasmuch as your testimony is extremely important, is we will take a break right now and I am going to call the technician myself. Thank you, Stephanie, for your indulgence.

Mr. DASCHLE. I would ask unanimous consent to insert the statement in the record at this time.

Mr. KILDEE. Without objection, it will be inserted in the record.

AFTER RECESS

Mr. KILDEE. We will reconvene and try it. Hopefully the technician will be coming to correct the situation.

Stephanie, we will start again and you have a mike and hopefully it will stay with us. The technician is on his way. The gentleman is familiar with the equipment and I think he has got our voice back. Proceed, Stephanie.

Ms. FOX. My name is Stephanie Nicole Fox, a student at Mandaree Public School.

Mr. KILDEE. Pull the mike very close to you like I have mine.

Ms. FOX. I am a student at Mandaree Public School in Mandaree, North Dakota. Mandaree High School is located on the Fort Berthold Indian Reservation. The Three Affiliated Tribes, Mandan, Hidatsa and Arikara Indians, live on this reservation.

I am from 1 of the 10 tribes of the Dakota Region. There are six Indian reservations located in the State of South Dakota and four Indian reservations in the State of North Dakota.

The Indian youth on or near these 10 Indian reservations need alcohol and drug related programs. I am very glad and happy that this committee is having public hearings on H.R. 1156. After having studied H.R. 1156 I believe that it is needed. The bill is a good starting place to begin meeting the needs of the Indian youth who have problems with alcohol and drugs.

I like the provisions under title II, education, and title V, juvenile alcohol and drug abuse treatment and rehabilitation, of the bill.

In title II, education, it provides for training of counselors in counseling techniques relevant to alcohol and drug abuse. The school counselor makes the most contacts of students who have alcohol and drug problems. If the counselors have this training, they will make the most impact on the Indian youth who are having alcohol and drug problems. As a rule, in most of the schools located in the Dakota region the counselor/student ratio is much higher in favor of the students. This high ratio makes it clear that the counselors need this training so that their time with the Indian youth is spent efficiently.

Another feature that I like under title II is that the schools that are located on these Indian reservations can be used during nonacademic time to provide alternative activities to using alcohol and drugs. This will ensure the establishment of summer recreation and counseling programs. The summer months is the time when much alcohol and drug problems exist on these ten Indian reservations. If the schools on or near these Indian reservations are open in the summer to provide recreational activities and counseling to Indian youth, it would greatly reduce the alcohol and drug problems.

The other title that I would like to make some comment on is title V of the bill. I support the conduct of the study that is required of the Indian Health Services under section 501. We all know that there are alcohol and drug problems with Indian youth, but there are very few studies conducted. The alcohol program under our tribal council is having a time trying to deal with the three items under this section. This study will help our tribal council by providing a copy of the report to them. I am sure other tribes would like to see the results of this study.

The director of IHS must provide comprehensive alcohol and drug abuse treatment services, including detoxification and counseling services, and follow-up care in Indian Health Service facilities, and in facilities operated under contract under Public Law 93-638 to Indian juveniles and adults in need of such services. I feel that the provisions under title II and title V will start to help the Indian youth who have alcohol and drug abuse problems.

I thank the chairman and the committee members for the opportunity to testify on H.R. 1156.

Thank you.

Mr. KILDEE. Thank you very much, Stephanie.

So far in the previous panels there has been emerging the idea that, in addition to this bill which will provide some immediate help here, there is also a need to look at some long-term causes: better educational opportunities, job opportunities; I think Leonard mentioned the alienation from the traditional culture of the tribes and also recreation facilities were mentioned as some of the means of preventing this alcohol and drug abuse.

Would any of you care to comment on that or maybe add some things in addition to that. Let's see, how about Renee.

Ms. SAUNSOCI. On the facilities that I think would really help with a lot of the young people on these reservations, from what I found out in my research with different agencies that I interviewed, all of them expressed a need for a facility, a recreational facility that young people can go to and to find something to do in a positive way. There is a lot of negative reinforcement among Indian youth on reservations. If we can do something to change that around with the help of this bill, that would greatly decrease, I think, decrease the alcohol and drug abuse problems among our Indian youth. I feel that this bill would help each and every one of our tribes in the way that we could have some funds set aside, especially for Indian youth prevention programming.

And in my research that is also what was the problem with programs. They were not designed for Indian youth. They were alcohol programs on my reservation, but they mostly dealt with adults, and these adults were in extreme drug abuse and alcohol abuse stages. The people that I spoke to with our alcohol program said that they did not have the funds, the staff and the time to be able to develop anything for Indian youth, and they felt a strong concern on this whole subject. They were in great support of me coming here, and that someone was from our tribe, from Nebraska, to express this need for us.

I found out that in Nebraska there is no facility at all available for Indian youth. In one case that I found out, they had to send a student or a young man who was in trouble with alcohol and drug abuse out of State to an Indian-oriented facility because they felt, the people, the professionals felt that this facility would help him since it was Indian oriented. They felt that he would not be able to function in a non-Indian rehabilitation facility because of the culture shock that he would go through. He had a lot of problems. They tried before and he had a lot of problems in going through the whole program because he could not relate to any of the other people of his age. They were not Indian and he was raised on a reservation.

Mr. **Kildee**. Thank you very much.

Mr. Daschle, we have a witness, I think, from your State. You might have a question.

Mr. **Daschle**. Thank you, Mr. Chairman.

In the interests of time I am not going to ask any questions except to welcome Traci and the entire panel. As I said a moment ago, I think these panelists have been excellent. We are pleased she was here. This is an area that is very, very dramatically affecting the people of our State, of our reservations, and I do not think we could have better witnesses and better talent expressing the need for some kind of corrective legislation as we have this morning. So I am grateful to them and grateful to you, Mr. Chairman, for holding the hearing.

Mr. **Kildee**. Thank you.

Mr. Bereuter, I think you have a witness also, a witness from your State.

Mr. **Bereuter**. Thank you, Mr. Chairman.

I want to thank the panel for their testimony, particularly Renee Saunsoci for her comments and the comments from our North Dakota friends. Thank you very much. You are helping us to make decisions that I think will be very beneficial to Indians and juveniles throughout the country.

Mr. **Kildee**. Mr. de Lugo.

Mr. **de Lugo**. No questions.

Mr. **Kildee**. Mr. Cheney.

Mr. Lowry.

Mr. **Lowry**. No questions.

Mr. **Kildee**. Mr. Moody, do you have a question?

Mr. **Moody**. No questions.

Mr. **Kildee**. I want to thank you, the panel, and you bore up under very adverse technical problems here.

Traci, do you have any comment you would like to add before we dismiss you?

Ms. **Rouillard**. I would agree with Renee we need more recreational facilities for the youth. You know, it does not really help to have all these treatment programs. When they get out, they still have nothing to do. I know people who have gone through the program and 1 week later they are sitting around and have nothing to do and so they are back drinking and taking things. So I would like to stress we need more recreational things on the reservations.

Mr. **Kildee**. What we are hearing from you, Traci, and the other panelists is that this bill is important and that this bill would be helpful; but we have to get also to the root causes, address the root causes. This bill is only part of the solution, but it is a very important part. Does that pretty well cover it?

Ms. **Saunsoci**. Yes.

Mr. **Kildee**. I want to thank the panel very, very much. I dismiss you and ask for the next panel.

Our next panel consists of Ms. Anne Abeita, Shoshone, Wind River, Wyoming, accompanied by Mr. Scott Murray, Shoshone, and Ms. Trina Stewart, Grand Traverse Band of Ottawa and Chippewa student of Michigan.

Ms. Abeita, you are the lead witness and others will be able to join in. I welcome particularly Trina Stewart from Michigan.

Trina, what part of Michigan?

Ms. **Stewart**. Traverse City.

Mr. **Kildee**. My father was born in Traverse City, and I welcome you especially today.

Ms. Abeita.

[Prepared statement of Anne Abeita may be found in appendix II.]

STATEMENT OF ANNE ABEITA, SHOSHONE, WIND RIVER, WY, ACCOMPANIED BY SCOTT MURRAY, SHOSHONE, AND TRINA STEWART, GRAND TRAVERSE BAND OF OTTAWA, AND CHIPPEWA STUDENT OF MICHIGAN

Ms. **Abeita**. My name is Anne Abeita, and I am 17 years old. I am enrolled Shoshone member of the Wind River Indian Reservation in Wyoming. I attend Wyoming Indian High School. I am a student body president right now.

We, the representatives of the Wind River Indian Reservation Youth Council, wholly support the intent of H.R. 1156 "Indian Juvenile Alcohol and Drug Abuse Prevention Act."

The suicide epidemic occurring on our reservation, Wind River Indian Reservation, Wyoming began in August, 1985 and claimed

12 young lives, 12 and just 3 weeks ago it was 13. Alcohol and drugs were misused in 90 percent of these incidents. Specific to most reservations are environmental factors that contribute to abuse of alcohol and drugs. Some of these factors are the breakdown of tribal tradition, lack of effective Indian adult role modes, alcoholic parents, broken homes, unemployment, early marriage and parenting and school failure.

Some measures that we envision to reduce the rate of alcohol and drug abuse are:

Recreation: Facilities, funds and parental involvement are needed. Additionally, the facilities can house educational materials for drug and alcohol abuse prevention, suicide prevention and a help hotline using peer counseling.

Use of Tribal Elders: The tribal value system and traditional ways of coping with modern-day stress can be modeled.

Education: Because of the high incidence of alcohol and drug abuse among the reservation youth, the reservation school curriculum will include drug and alcohol abuse education at K–12 systems and Headstart programs.

Parental involvement: Community resources such as churches, parent groups, and local resource agencies can impact parenting skills, teenage pregnancy, effects of alcohol and drug abuse contributing to adverse home environmental factors.

We are in agreement with other tribes and organizations that another level of management is not necessary to deal with these many problems. The Bureau of Indian Affairs and the Indian Health Services should be able to identify available resources. The Community Health Representatives could be a primary outreach resource.

Thank you for giving us this opportunity to express our views on H.R. 1156.

From my own perspective I would say that about 65 to 70 percent on our reservation are involved in alcohol and drugs, but in the school that I go to there are 180 students, and it is 100 percent Indian students. I would say that 95 percent are involved in alcohol, but the exact percent of alcohol and drug users is not given out from IHS and that detracts from the percentage rates. But from my own perspective those are the percentage rate on my reservation and my school.

The Community Health Representatives are short staffed. They do all they can, but since the suicides that just happened, this program went in the red $250,000, and the CHR program has played a critical role in helping with these suicides, which 90 percent were involved in alcohol and drugs.

That is it.

Mr. **Kildee**. Thank you very much.

Let me ask you this question. What can the Government of the United States, which has a sovereignty-to-sovereignty relationship with the Shoshone tribe, the Shoshone Government, what can we do better to work with that Government so they in turn can, address the tremendous problem of youth suicide and, you say, the drug problem in general there? Do you think that the United States should be having such a dialog? We have a dialog with governments in Paris and London and Tokyo; yet we have a Government-to-Government relationship with the Shoshone Tribe. Could we be doing a better job dealing with the Shoshone Nation to help them address this problem?

Ms. **Abeita**. I think the Government should—and I know that we have not been helped too much because of the fact that we do not have enough funding to help like in recreation, to help with different programs; and like I mentioned, that the CHR staff were short on staff and that we did go in the whole $250,000 from helping out with these suicides.

Mr. **Kildee**. All right.

Mr. Cheney.

Mr. **Cheney**. Thank you, Mr. Chairman.

I would like to welcome our two students from Wyoming here today. Both are presidents of their respective student bodies and distinguished leaders of the schools from Fremont County and up on the Wind River Reservation, and I do appreciate your presence here.

I believe, Scott, that you have been nominated to serve or attend the U.S. Naval Academy; is that not correct?

Mr. **Murray**. Yes, sir.

Mr. **Cheney**. We look forward to a distinguished career for you in the years ahead.

I want to focus, if I can just for 1 minute, on the suicide problem which, of course, has received a lot of attention where Wyoming is concerned and the Wind River Reservation. Can you say anything more at this point? Do we know any more about the causes, about why we have this wave of some 12 suicides and now 13? I have talked with some of the social workers who have been involved in trying to put together a program to counsel students. Do you have any thoughts or ideas on that problem? It is not unique, certainly, to the Wind River Reservation. As I mentioned earlier, I know of the circumstances here in the Washington area where it has occurred as well; but it seems to be especially pronounced and difficult to deal with where the reservation is concerned.

I wonder if either one of you would have any comments you care to make, any light you could shed on why it happened and what kind of progress we are making in trying to deal with it.

Ms. **Abeita**. I think it was mainly because there is nothing really to do on the reservation, and so that is why they turn to alcohol and drugs and then that causes—that was because there is no recreation on the reservation, and I feel that was the main problem and that is why they turned to this alcohol and drugs and it made them want to do that more. Well, you know, when a person is like going to kill themselves and they are drinking, it is going to make them want to do it even more because they are not in the right mind, they do not know what they are doing.

And there is not any recreation on the reservation, but just recently the Arapaho and Shoshone Council signed to have a Wind River Indian Youth Council on our reservation that was organized and helped by Mr. J.R. Click, and it was signed in December and we are having Youth Council meetings and that started in January; and I think that this reservation Youth Council is going to help out a lot because they have meetings and we form different types of activities for the reservation, for the kids, and so I think that is going to help out a lot.

But we do need more different programs to help, like to help the adults because I think another main problem for this alcohol and drugs and the suicides is because the parents are not educated in knowing about alcohol and drugs, and so they do not know how to approach the children or the youth, how to help them. So I think we need programs for the parents to get involved and know about these types of problems so they can help the children.

Mr. **Cheney**. Scott, have you got anything you would like to add?

Mr. **Murray**. Yes, sir. I think the main problem lies in the socioeconomic conditions which exist. Unemployment on the reservation is estimated as high as 85 percent, and the only true income that is paid into the area comes from the oil royalties paid for the minerals on our reservation. This used to be as high as $500 a month. It has dropped to $300 a month and is again cut down to $150 a month. This has led to a lack—there is no need for the people to work, they feel, and with this supplemental income they are able to relax and with idle time they get involved in the drugs and alcohol, and this is one of the larger problems, that there is this money that comes in the hands—that is, you know, they are on the social programs and stuff and they do not work so there is free time.

Another problem is the law enforcement. On our reservation we have approximately 3,000 square miles of reservation and we have 5,000 residents. We have nine police officers to patrol this area. As the work schedule routes through three shifts, this means that at one time on the reservation there are only two officers patrolling the entire area.

Also, in the area of rehabilitation, the only drug/alcohol rehabilitation in practice on the reservation is called Sho-Rap Rehab. It is administered by the tribes. It is an Alcoholics Anonymous program which is funded by the tribes. There is no section in there, no division for juveniles or youth programs to go along with that. Also there are no juvenile facilities. At this time they are building a new jail on our reservation and for the first time we will have juvenile facilities in the jail. Before this time they were incarcerated with the adults.

Also, there are no existing recreational programs for youth on the reservation at this time. I think that our priorities here are: number one, education; and, number two, to provide alternatives to drugs and alcohol problems. I think by alternatives we do not mean only to provide recreation, but also work programs and things, vocational programs where these people are given experience in the work force, where they can learn to work and learn to contribute. I think this would help, this would take away a lot of idle time and would also give them the ability to move into society and take up their place.

Thank you, Mr. Chairman.

Mr. **Kildee**. Mr. Lowry.

Mr. **Lowry**. No, thank you.

Mr. **Kildee**. Mr. Moody.

Mr. Richardson.

Mr. **Richardson**. Thank you, Mr. Chairman.

I want to commend you and all those involved in drafting this legislation, Mr. McCain, Mr. Daschle. I think it is important. I have chaired hearings in New Mexico and Arizona on the subject, and I am very proud I have got some New Mexicans here, not only Celeste Toglena from Shiprock, but Lloyd Talas.

I wish to commend you, Mr. Chairman. I have no questions now. I may like to ask some later.

Mr. **Kildee**. Thank you, Mr. Richardson.

Mr. **Richardson**. I ask unanimous consent to put my statement in the record.

Mr. **Kildee**. Without objection.

[Editor's note.—Prepared statement of Hon. Bill Richardson may be found in appendix II.]

Mr. **Kildee**. Trina, you are from the Traverse City area. Are you living on the reservation or off?

Ms. **Stewart**. I am off.

Mr. **Kildee**. Do you find among any of the people off the reservation there is a similarity of some of these problems also, the drug and alcohol abuse?

Ms. **Stewart**. Yes.

Mr. **Kildee**. Do you know of any programs there? You go to the public school system in the Traverse City area?

Ms. **Stewart**. Yes.

Mr. **Kildee**. Do you know if they have any programs for the student body that relate to drug and alcohol abuse?

Ms. **Stewart**. I only know of one and it is through the Grand Traverse Band of Ottawa and Chippewa Indians, and that is the only one I know of.

Mr. **Kildee**. Do you think this bill, Trina, is part of a package perhaps that would be helpful in addressing this problem for the Indian people of this country?

Ms. **Stewart**. Yes.

Mr. **Kildee**. Do you find much drug and alcohol abuse in your school?

Ms. **Stewart**. Yes.

Mr. **Kildee**. Are you familiar with the reservation nearby? Do you have friends or relatives on the reservation?

Ms. **Stewart**. I go out there once in a while, but we have not really friends out there.

Mr. **Kildee**. Is there a problem there on the reservation also?

Ms. **Stewart**. Yes.

Mr. **Kildee**. Thank you very much, Trina.

Mr. Moody?

Mr. **Moody**. No.

Mr. **Kildee**. I want to thank this panel again. All your written testimony will be made part of the written record. You will receive copies of that, and we appreciate very much your help on this hearing today. Thank you very much.

The chair is going to try something to expedite things. Teachers experiment once in a while. What we are going to try to do at this point is I am going to try to bring two panels up here and give the two lead people equal time in their presentations.

So we will bring the panel of Mr. Lloyd Talas, Hopi, Sante Fe Indian School student of New Mexico, accompanied by Mr. Greg

Mendoza, Pima, Arizona; and that panel will come up. And we are going to sit some extra chairs out, and then we will have the panel headed by Ms. Jill Carey, Cherokee, Sequoyah Indian High School, Oklahoma, accompanied by Mr. John Daugomah, Kiowa, and Ms. Shawn Soulsby, Pawnee. So if those people would come up, the two leadoff witnesses will remain in the same order as the program indicates, Mr. Lloyd Talas and Ms. Jill Carey.

Lloyd, you want to start off and we will go to Jill and then we will have questions of the entire panel.

[Prepared statements of Lloyd Talas and Jill Carey may be found in appendix II.]

PANEL CONSISTING OF LLOYD TALAS, HOPI, SANTA FE INDIAN SCHOOL, NM, ACCOMPANIED BY GREG MENDOZA, PIMA, AZ; AND JILL CAREY, CHEROKEE, SEQUOYAH INDIAN HIGH SCHOOL, OK, ACCOMPANIED BY JOHN DAUGOMAH, KIOWA, AND SHAWN SOULSBY, PAWNEE

Mr. Talas. Honorable chairman and committee members.

My name is Lloyd Talas and I am a Hopi Indian student attending the Santa Fe Indian School, which is a tribally operated contract school for approximately 500 students of grades 7 through 12. I have been a student at the Santa Fe Indian School for the past 4 years. I feel that the school has been a great asset to me and other students and it will continue to be for years to come. It has been an educational and learning experience for me, which includes learning to cope with alcohol and drug abuse situations in school and at home.

I feel it is a great honor to come today before you to present testimony, to help combat these problems among our Indian youth, which is a problem which is affecting our Indian people, especially the youth who are going to be the future leaders of tomorrow.

My personal and general observations of alcohol and drug use and abuse is that it affects everyone and not only the users and abusers. I have seen my own family, relatives, friends and others and how it has had an effect on them and their lives and at times where it was devastating. It causes destruction through death, accidents, violence, incarceration, breaking up of families, suicide or attempts at suicide and crime. Yet you see alcohol and drug usage glamorized in newspapers, magazines, radio, television, billboard displays, posters, album covers, music, hard rock bands and many sources. Alcohol, marijuana, inhalants and other drugs are especially easily available and can be obtained just about anywhere you turn. You can get them from your own parents, brothers, sisters, relatives, peers, friends, bootleggers and even people you do not even know who will actually approach you.

One of the biggest obstacles, especially with alcohol, is that it is accepted by the general public and society as a whole. With alcohol and other drugs, it is OK to do as much advertising as one is allowed to and usually it is allowed to go overboard a lot of the time. These are some of the things we see as young people.

Problems resulting from alcohol and drug use and abuse among Indian youth are phenomenal. In the school and at home many young Indian people spend their money on alcohol and other drugs and have nothing to show for it except hangovers, being arrested, being sent to the detention center, being sent to the corrections home, being written up for a substance abuse incident, having to appear before a tribal council/judge or probation officer, and an involvement in accidents.

Negative attitudes and behavior are built into and evident in young Indian people that are involved with alcohol and other drug use and abuse. You see a lack of concentration and participation in school work and activities and the inability to complete assignments or tasks. Many Indian youth get into fights, arguments and other personal conflicts. They shut out other people who are willing and wanting to help them and guide them in a positive way. Their personal hygiene is affected, and this can be seen through their lack of cleanliness and the way they dress. You see the lack of respect for themselves, elders, parents, staff and the law. Most important of all, they lack respect for their cultural and traditional way of their respective tribes. It causes disunity among our own people, both young and old. Other problems are a high rate of dropouts, being dismissed from school because of alcohol and drug use and abuse, absence from classes and discipline.

These are but a few problems mentioned that we, as young concerned people, see as a result of alcohol and drug use and abuse among Indian youth in our area. To put it simply, alcohol and drug abuse is very damaging to the Indian youth, spiritually, mentally and physically. Many hopes, dreams and goals of individual Native Americans and tribes have not been achieved because of alcohol and drug abuse and the problems they bring. We, as Indian youth, must be assured that people working with us in this area or field are themselves emotionally stable.

The needs are many. There are programs in place, but many of them are geared toward working with adults. There have been occasions where young people were placed in these facilities for treatment and could not relate to what goes on. They also felt uncomfortable because of the age difference. This is especially true with young Indian people that are referred to some of these facilities. We need facilities for young Indian people that are geared towards their rehabilitation using our own traditional and cultural awareness people. Together with other prevention, intervention and alcohol/drug education activities would give us more pride and self-esteem. We need more involvement by all our Indian people to unite and work together in combating this problem.

We need more programs aimed at prevention and intervention. That is not to exclude treatment programs, both inpatient and outpatient. We need a lot of family involvement during the treatment process and after the process. We need good community programs to work with our school programs to better serve the Indian youth. In school we have alcohol/drug counseling education and are taught coping skills, life skills, but a lot of time there is no follow-up from community-based programs that students are referred to during the summer.

We need money provided to schools to provide more community outreach. In law enforcement, there needs to be a study made in how they deal with public intoxication, DWI and other alcohol/drug related situations among Indian youth. We need stricter laws for the selling of alcoholic beverages (checking IDs, setting up the legal age limit for buying alcoholic beverages at 21 years old for all states, law enforcement agencies keeping a closer watch on possible bootleggers). Laws need to be amended to prohibit or censor certain information on alcohol and drug advertisements. These needs are endless.

Most important of all is to implement these programs and to work together on the needs expressed by all of us to combat alcohol and other drug use and abuse among Indian youth through prevention, identification, treatment and follow-up as proposed in H.R. 1156. I hope that our concerns and comments will seriously be considered in the final analysis and draft of H.R. 1156.

In conclusion, I would like to thank the committee for giving me the opportunity to present some personal and general observations in regards to problems resulting from alcohol and drug abuse among Indian youth and the needs for this growing problem. I would also like to thank the Santa Fe Indian School for giving me this opportunity to be here. May the Great Spirit bless you all.

Mr. KILDEE. Thank you very much, Mr. Talas. I have had the occasion to visit your school out there, and please give my greetings to Mr. Joe Abeyta, your superintendent.

The next witness to testify is Miss Jill Carey. Pull that microphone very close.

Ms. CAREY. Mr. Chairman and members of the committee.

My name is Jill Carey and I am a Cherokee Indian. I am 18 and am presently attending Sequoyah Indian High School, one of the 6 off reservation boarding schools in the Nation. I do not wish to give a flowery, overdone statement. I wish to convey my own deep personal concerns with the problems I see affecting my closest peers and friends.

There are approximately 125 students attending Sequoyah High School and out of that number at least 90 percent are frequent users of alcohol and/or drugs; out of that number at least 50 percent have serious addiction problems. These are alarming and extremely serious ratios.

Before I go any further, I would like to share a few facts with you. One hundred sixteen years ago today the treaty of Fort Laramie was signed with the Sioux lands and their allies establishing the great Sioux reservation in South Dakota. The same reservation where today 2 out of 3 of their youth ages 12 to 18 are chronic alcoholics, and 2 out of 3 of all teenage girls under 17 become unwed mothers, giving birth to alcoholic infants. In 1984 there were more Indian children in Government boarding schools than there were Cherokees on a forced march to Oklahoma which was our infamous and tragic Trail of Tears in the 1830's.

Just 25 miles from Tahlequah, where I live in Adair County of Oklahoma, the teenage alcoholism and teenage pregnancy rates are higher per capita than Harlem in New York City. Oklahoma is tenth in the Nation for arrests connected with teenage drug and alcohol abuse.

The devastation and havoc that this problem creates has touched all of us, not just those who are victims of its grip. But as our youth are torn away from that love of Mother Earth, it spawns corruption and decomposition of all that we as human beings hold dear.

I have no technical recommendations. All I have is the support for anything that can intervene in the path that the future of our Indian youth are on.

As a Christian, I know that the only way that these young people will survive and rise above the ashes and rubble is with the help and uplifting of our Heavenly Father. But every amount of help and support and expression of genuine love that we show these individuals will help the healing process. This bill will help give them the chance to become healthy, whole, productive citizens. We all deserve at least that chance.

Before I end, I would like to say that we can blame this on many problems and things, and I live in a dorm and I know the kids, what their problems are, and what they say because they come to me. Lack of activities I cannot blame it on because we have football, basketball, baseball, golf, tennis, recreational center. Whenever they are given the chance to go off campus, they abuse it. I am saying they as those that drink. Whenever we get together a group of people to go to churches and sing, their attitude is totally changed. They are willing to give up the things and they feel positive, and I feel that we can give these clinics and counselors and things like that; but if they are not willing to change within themselves, then we have to give them a positive attitude. They have to feel assured. In our schools and classes it affects them in ways that their grades suffer and they are not self-motivated; and I feel that we need to—I feel this needs to be done, and I thank you for the opportunity to explain this to you.

Mr. **Kildee**. Thank you very much, Jill. Your testimony reminded me of my basic philosophy as I approach Government. I think Government's prime obligation is to promote, defend, protect and enhance human dignity, and I think all the bills that we pass on and look at we should ask ourselves does this promote, defend, protect and enhance human dignity.

As I mentioned earlier, I have three teenage children. The youngest is a boy 13, girl 15 and a boy 16. When my 13 year old was 9 years old, 4 years ago, I was tucking him in the bed one night as is my custom being the father of the family and hearing his prayers. And he said his formal prayers and he said, "I love God, I love Mommy, I love Daddy, I love Laura, I love David and I love me." It is very important that people have a good image of themselves, and I think that is part of that promoting, defending, protecting and enhancing human dignity and every human being, Anglo, Indian, European, Asian. Every human being has enormous dignity and great worth just by the very fact that they are human, great worth. We should try to help people understand their dignity and worth, and I really appreciate your testimony.

Mr. Richardson.

Mr. **Richardson**. Thank you, Mr. Chairman.

Lloyd, let me start out by asking you, at your school, Santa Fe Indian School, what percentage of the students would you say were constant users of either drugs or alcohol?

Mr. **Talas**. About 20 percent of the students.

Mr. **Richardson**. Twenty percent. You mentioned the need for Government programs. You mentioned the need for outpatient clinics. Have you or the panel considered some of the things that you guys can do? How about a student task force initiated by yourselves? Is that within the realm of possibility, an anti-drug task force that you on a voluntary basis have done independent of any programs? What will you do if this bill does not pass? You have heard about the reality of the budget and this is an excellent bill, but I do not think the administration is for it. We need some more alcoholism funding, but you have heard of this specter called Gramm-Rudman. What if all of a sudden there is no program for next year that requires congressional action? Would you consider that option, student task forces yourselves, on a voluntary basis, fighting it on your own? Is that realistic?

Mr. **Talas**. Right now at the school we have several programs that deal with these things, and to me I think they are pretty good programs too. We have several programs that deal with the substance abuse and counseling and prevention and many, many—there is one program that students that are severely involved in alcohol all the time, they are referred to a program called IRG; that is Intensive Residential Guidance program that we have up there. If they are caught like more than once they are put into this program. They are really checked upon to see if they are abiding by the program.

Mr. **Richardson**. Jill, what about your view on this? I am talking more in terms of a student vigilante, anti-drug effort yourselves. Yes, you have a lot of these counseling programs, but public education, exposure of the other students that are involved, is that realistic?

Ms. **Carey**. Excuse me. Would you repeat the question.

Mr. **Richardson**. What I am saying is that assume that this bill, which is a fine bill, does not pass and there is not any more funding. Is it an option for students themselves to educate one another without parents perhaps, without the community, yourselves on your own? Is that something that you considered or contemplated?

Ms. **Carey**. Yes. I feel that the kids, if it is just us, we have gotten a group together and talked about things and it has worked out. I feel if the group gets together and they know the problems of each other, you know, they have been through the same thing, I feel it helps.

Mr. **Richardson**. Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you, Mr. Richardson.

Mr. Synar.

Mr. **Synar**. Thank you, Mr. Chairman.

First of all, let me welcome Jill and all the other Oklahomans here today. It is good to have you all up here, and what you see today happening in front of you is government in its most primary form where we take input and hopefully get a better understanding of what we are trying to do to help. I wish many of your parents and also some of our other constituents that live in Oklahoma could come up and have this type of exposure, because I think this would give them a better understanding of the problems we do face and how we try to deal with them; and all of you who are here from all over the country are to be commended for a number of reasons: first of all, for helping us come to the solutions with respect to this serious growing problem; but, secondly, you are to be commended because many of you are out there in the forefront trying to fight this problem. It is with a great amount of pride that I think all of us sit on this side of the aisle and look at you and say this is nice to see, that these people are really out there trying and with or without federal money they are going to deal with it.

I would like to ask one question, and then I will ask both our panelists this. Obviously, you both talked about it is nice to have the clinics and the supervisors and the type of programs that are available, but it is also nice to have a lot of activities, and the failure out there is not the lack of activities and things to do because there is plenty of things to do; that the real answer comes in self-motivation, as Dale pointed out in his very eloquent comments. It comes down from one having that good self-image about themselves.

Maybe this question is broad, but maybe you all can enlighten us. What are we doing wrong with respect to all programs that affect our community and youth where we are having this symptom continue to grow? What is it we are failing to do from this level that would help eliminate this direction towards the use and abuse of alcohol and drugs?

What is it that we are not doing?

Ms. Carey. It is great you are giving us an opportunity to be able to speak out. It is like we said, it is self-motivation and we need that. At our school there is a lot of peer pressure and that is not your problem. It is a fact of life we live in. Everyone must be cute and keep up with each other in clothes, hair, just things of that sort. A lot of peer pressure has to do with the students, I think, because, you know, we live on the campus and the teachers and stuff—the teachers are very supportive. A lot has to do with the students and problems they have. When you come to a boarding school, you realize that they have a lot of problems. Their parents have left them alone. A lot of things—they have been there. Some may have been molested. There is a lot there, and you have to give them confidence.

And I feel if we have a counselor that was educated in this area, where they could trust that person, feel confidence in that person, it evens works for students. If they trust that student, they will come to that student; but the student does not have as much higher position to be able to come out and tell.

Mr. Kildee. I think Shawn wanted to reply to that too.

Ms. Soulsby. The statement I wanted to make is you have a lot of concerned youth here; and if the organizations that are in existence would implement some kind of program where the youth could come in and set up their own system for their own people, these kids here know what the problems are and they know the solutions, but they have not got the facilities nor the facilitators to put those into action.

And I think right here you have got a whole room full of kids that would be willing to go back to the places they come from and they would be willing to help start those programs if they were given the guidance and leadership.

Just something, when I was 17 years old I moved away from home and I moved to New York City and I ran into some problems up there and I spent 6 months in the New York State correctional facility because of charges related to drug and alcohol abuse. And if at that point in my life I had had people my own age who were concerned and that were involved with programs like that—I mean I had a lot going for me when I was in high school. I came from a well off family. I had a nice position in high school, but there was not just the concern from peers. And I think we have got all the power we need right in this room, you know. We need a little help financially. We need a little help from some facilitators, but I think we have the potential and the power right here to make a big impact on the problem we are talking about.

Mr. **Synar**. I appreciate both those remarks. Let me go at this again because what I am trying to figure out is what is it that we are not doing? I mean, are the institutions such as Sequoyah or the schools failing to do something that is causing a boredom level which is forcing that or does it come down to strictly peer pressure? Since everyone else is doing it, you feel like you got to get in the program. Is that it more than the failure of anything we are doing or not doing?

Mr. **Daugomah**. I would like to try to answer that if I may. Speaking as a youth, we tend to follow the lead of our elders, meaning our parents, and our parents had to go through some traumatic times where they faced a lot of things like, oh, inadequate education, housing, unemployment; and if you take a look at what is going on with the farmers now where there is a high suicide rate, a high alcoholism rate, that they are facing problems that the Indians have been facing for many years. Because of these inadequacies the adults themselves have faced, these traumatic problems, turned to alcohol and in setting that kind of example or suffering those kind of problems, their offspring are going to follow the same suit.

And it is up to—I do not know. You asked what can you do from that level, and I think improving some of the trust obligations that the U.S. Government is obligated to do is, I think, one of really getting to the root of the problem, where we could improve on employment, education and housing. I think that is really where the root of the problem is. Myself, I experienced that also. I lost a mother to alcoholism in 1979. I grew up in a boarding school, went to school at boarding school for 5 years, and I ran into these kind of same peer pressures; but it was not because the kids—it was the peer pressure, but they were following a trend that was set by the parents that suffered these inadequacies earlier in their years. And I think if we can—from your level, if you can focus on providing some of those trust obligations, then it would solve a lot of problems.

Mr. **Synar**. Thank you very much.

Thank you, Mr. Chairman.

Mr. **Kildee**. I thank the panel for being a very fine panel. We will dismiss you at this time. Again, I may be leaving soon as my own bill is up on the Floor. If any of you are around at 2:30, 3:00, when I hopefully will get my bill passed, if you want to drop by my own office, 2432 of this building, fourth floor, I would be glad to meet with you individually or as a group. Thank you very much.

Same procedure. We will bring two panels up together. Next panels will consist of Mr. Oscar Schuyler, Oneida Tribe of Wisconsin, accompanied by Joely Armstrong, Lac du Flambeau, and Ms. Lisa Sutton, Lac Courte Oreilles. That panel can come up and I will join them with the next panel consisting of Mr. Tony Stacona, Warm Springs Tribe of Oregon, accompanied by Ms. Billie Peterson, Skokomish Tribe of Washington and Ms. Bridgette Kelama, Nisqually Tribe of Washington.

I think some of our people may have had to leave, so those who are here, if you will identify yourselves for the court reporter as you begin for the record and Mr. Synar here.

[Prepared statements of Oscar Schuyler and Tony Stacona, with attachments, maybe found in appendix II.]

PANEL CONSISTING OF OSCAR SCHUYLER, ONEIDA TRIBE OF WISCONSIN, ACCOMPANIED BY JOELY ARMSTRONG, LAC DU FLAMBEAU AND LISA SUTTON, LAC COURTE OREILLES; AND TONY STACONA, WARM SPRINGS TRIBE OF OREGON, ACCOMPANIED BY BILLIE PETERSON, SKOKOMISH TRIBE OF WASHINGTON, AND BRIDGETTE KELAMA, NISQUALLY TRIBE, WASHINGTON

Mr. SCHUYLER. Gentlemen, I am Oscar Schuyler of the Oneida Tribe. It is an honor for me to be here to represent the Oneida UNITY.

We feel that there is a drug and alcohol abuse problem among the youth in our community and in many other communities on reservations. We feel that this problem is mainly caused by youth trying to fit in, peer pressures and divorce and all the little problems added up to one big problem.

I know one kid that drinks, does not touch drugs, but drinks a lot. When he first started drinking his mother said it was okay, but then he started to drink too much and started to get into arguments with his mother all the time. Then he moved, to go live with his father. He did this back and forth for about 1 year. He finally decided to stay with his father. He stopped drinking for a long time. He then turned 19 and felt he could drink again and hold it to a limit. He did until he started to get depressed and all his problems came to haunt him and made him suicidal. His mother then came out for a funeral and to talk to him. We noticed that he went everywhere that day with her and got kind of attached to her again.

When she left he was OK for 2 weeks; then he started having problems with his girlfriend and turned to alcohol for relief. But it got worse and once again he became suicidal. He tried suicide five times in less than 1 month. The reason I know this person very well is because he is my brother. I feel that there is more people like this not only on the reservation but with youth all over the world. I feel to help these problems we need something that the whole family can go to instead of just the troubled youth. This should be a place with religion and where the families help out each other with the problems of their youth.

We as Oneida youth offer our support to H.R. 1156. This legislation can directly affect our future and the future of our loved ones.

The need for qualified people to work with Indian youth and families in the area of alcohol and drug abuse at the community level cannot be over emphasized. I think that the right way to run an alcohol and drug abuse program is to have the responsibility in the hands of people who are either themselves recovered alcoholics or who have lived in an alcoholism-plagued family and who are also willing to professionalize themselves.

I would like to thank you once again for the opportunity to offer again this testimony and the needs of Indian youth will not be ignored.

Mr. KILDEE. Thank you very much for your testimony.

Mr. Tony Stacona.

Mr. STACONA. Good afternoon, Mr. Chairman, members and staff.

My name is Tony Stacona and with me today are Alvis Smith, Stacey Leonard and Lisa Briseno. We are enrolled members of the Confederated Tribes of the Warm Springs Reservation of Oregon and are currently enrolled in Madras Senior High School. We want to express our gratitude to the members of the House Committee on Interior and Insular Affairs, other esteemed members of Congress and UNITY for this opportunity to testify on the Indian Juvenile Alcohol and Drug Prevention Act, H.R. 1156. We also want to convey to you the appreciation of our fellow students, our people, our school and our tribal government for giving us this opportunity.

We are extremely proud to support the intent and purposes of H.R. 1156. It will address one of the several critical needs of Indian youth—our peers. We want to commend and thank Congressmen Bereuter, Daschle, Udall, Young of Alaska, Williams and other sponsors for their sensitivity, foresight, and leadership in behalf of Indian youth. Passage of this legislation will contribute greatly to the spirit and quality of the Government-to-Government cooperation necessary for the protection and advancement of Indian human resource interests.

Alcohol and drug abuse remains at epidemic proportions within most Indian communities; no family has been spared the agony and hurt that it causes. Substance use and abuse often fuels a vicious circle that entraps and controls many lives; it is an addictive escape that can become a way of life. We can see the effects all around us: the lack of hope and feelings of powerlessness to bring about change or improvements. We are grateful to know that there are concerned people such as yourselves who are willing to help us and our community become all that we are capable of being or doing.

We have known that drugs and alcohol are a problem; we were not aware of the far-reaching impacts and costs. Our research and preparation for this testimony was enlightening. The information included these present findings found on the reservations:

Approximately 40 percent of Indian students may not complete high school with their class. Some may complete an equivalency program later.

Among tribal members between the ages of 19 and 27, only 17 percent are employed, 10 percent are enrolled in training and 73 percent are unemployed. We recognize that some of this age group are committed to domestic obligations; others may have given up.

The average age of death in 1985 was 32.05 years.

In 1985, off reservation residential treatment served 70 people (three were under the age of 18) at a cost of $539,125.

There were many other such statistics. We are pleased to report that our reservation has not had any alcohol related traffic fatality in over a year. However, 43 percent of auto accidents are alcohol related. We are making progress; yet much work needs to be done.

We have reviewed and analyzed H.R. 1156. We would like to make the following recommendations:

Title I, Interdepartmental Agreement. We recommend including the Secretary of Education to recognize the obligation and responsibility of the education community under section 504 of the Rehabilitation Act and the Education of All Handicapped Children Act.

Title II, Education. We recommend language that will not limit the responsibility to a few specific categorical programs as the principal source and base of this mandate.

Title IV, Law Enforcement. In addition to the arrest and follow-up provisions, drug and alcohol availability needs to be addressed by adding language to improve the interagency action for "supply side" and "demand side" enforcement.

Drug and alcohol abuse is a major concern of our peers, both Indian and non-Indian. Substance abuse by itself is only a symptom. We request that Congress and the administration pursue an interagency initiative to work cooperatively on solving the causes. A conceptual approach has been included with our statement. The approach can be expanded to establish a Federal interagency planning forum to ensure the best utilization of badly needed but diminishing financial resources. Working together we can make a difference.

In closing, we again want to express our most sincere appreciation for this honor to appear before you. Thank you for placing value on our thoughts and opinions.

Mr. **Kildee**. Thank you very much, Tony.

Mr. Synar, questions of the panel?

Mr. **Synar**. No questions, Mr. Chairman.

Mr. **Kildee**. Mr. Lowry.

Mr. **Lowry**. Thank you, Mr. Chairman.

I want to thank the two people who have testified for their excellent testimony and want to welcome two other people on the panel from our state of Washington, Billie Peterson of the Skokomish Tribe and Bridgette Kelama from the Nisqually Tribe.

Billie is the daughter of a good friend of mine who is the chairman of the Skokomish Tribe, Gary Peterson, and one of the outstanding leaders in the state of Washington, Mr. Chairman. As a matter of fact, the Indian leaders that I know are some of the most outstanding adults in the entire state of Washington; so as I sat and listened to the role model question, those Indian leaders I know are great role models.

And everybody, I think, in the room is really searching for why this problem is as immense as it is.

I would like to ask both Billie and Bridgette to respond. How important is the question of future employment opportunity for you, for Indian youth, and the relationship of the unemployment of the adults and how important is the employment question within this overall alcohol/suicide problem? Billie, would you care to answer that.

Ms. **Peterson**. Thank you, Mr. Lowry.

The employment question is very important around our area. The major source of employment in our area is foresting. Simpson Timber Company recently closed down several of its mills and a lot of people are out of work. I believe that employment will keep people out of drugs and alcohol and also I think that with employment, with parents who are employed, children grow up believing they should work. If the parents are unemployed, I think the role model that children have to look up to as being unemployed, they do not expect—they do not see themselves in the future working. So I think the employment factor is very important in our area.

Mr. **Lowry**. I assume it is sort of difficult to have a rosy look at the future if you do not think it is possible to have a job when you become an adult. You are almost—you are adults now. You know what I mean. You get a couple of years older. It seems to me it is kind of hard, Mr. Chairman, to have a rosy looking future if you cannot find a job. Is that right?

Ms. **Peterson**. Yes, it is.

Mr. **Lowry**. Bridgette.

Ms. **Kelama**. I think it is very strong. You have your parent support of getting a job because I got a job last summer and this is a very fine experience, learning now to work and what you are going to have to do, like taxes and stuff, because the young kids today have very much trouble doing taxes and stuff. I think this last year I had kind of trouble doing taxes. So I had to learn how to do this. So I think it is very strong that you have a chance to work and having your parents support you. Thank you.

Mr. **Lowry**. Where did you have your job?

Ms. **Kelama**. I was working fighting fire with the Government.

Mr. **Lowry**. Do you have friends or know people that are employed in the summer youth program?

Ms. **Kelama**. Yes. I think it is a good opportunity for young kids whose parents do not work, to have a chance to work and they have people of the community around them to support them if their parents do not.

Mr. **Lowry**. Thank you.

Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you very much, Mr. Lowry.

Mr. Moody.

Mr. **Moody**. Thank you, Mr. Chairman.

I am very happy we have a representative from Wisconsin here. Oscar Schuyler, I thought your testimony was excellent. Do you have any additional points you want to make?

Mr. **Schuyler**. No.

Mr. **Moody**. Do you think this bill is the right answer? Tony, do you think this is the way to go about it?

Mr. **Stacona**. Yes, but it is kind of a long process just for a bill to be through. The youth and everything, maybe move a little faster, you know what I mean.

Mr. **Moody**. Do you think that attitudes about alcohol and drugs can be altered by anything we might do here in Congress or do you think it is going to have to come from within the community itself?

Mr. **Stacona**. I think it has to come with the community and the parents coming together to help the problems.

Mr. **Moody**. Do you think the community perceives it as a problem? I know you do. Do you think the time is ripe for the community to take action on its own?

Mr. **Stacona**. Yes, for the community to act on its own we need the funds, and right now we are trying to get our community involved with the problem. We have what we call the TRAILS program. We got a recreation permit and if you get caught in their drinking, you get kicked out and you have to go to that program and talk to them and everything.

Mr. **Moody**. Do you think that program is effective? Is that working?

Mr. **Stacona**. It is working, but we need more—I do not know how to say it.

Mr. **Moody**. Support?

Mr. **Stacona**. Support.

Mr. **Moody**. Thank you very much.

Thank you, Mr. Chairman.

Mr. **Kildee**. Thank you, Mr. Moody.

I want to thank the panel. You are very clear in your testimony, and hopefully it will guide the Congress in doing what is right. I think I have always said many times, and I repeat it again, that we in this Congress are part of the trust responsibility—it is not just for the Interior Department or the BIA—Congress is part of that trust responsibility. We are part of the sovereignty-to-sovereignty relationship we have with the Indians. We have moral, legal and treaty obligations to the American Indians and Native Americans. And if the administration wants to cut back on education elsewhere—I do not support that—we have a special obligation in education to the Indian people of this country because when we took land we promised education. So we have that special treaty responsibility, and I think your testimony here today will help us carry out that treaty responsibility.

Thank you very, very much. I dismiss the panel.

We will do what we did before; we will join the panels together here again for our final presentation. Mr. Jason Wyasket, Northern Ute Tribe, Fort Duchesne, Utah accompanied by Ms. Kelly Bliss and Ms. Stacey James, Washoe Tribe of Nevada and California; Mr. Kenneth Grant, Mississippi Choctaw Tribe.

We particularly appreciate the patience of this last panel. We are behind schedule, but we do appreciate your bearing with us on that.

Our first witness will be Mr. Jason Wyasket. Jason, pull that mike very close.

[Prepared statements of Jason Wyasket and Kenneth Grant may be fond in appendix II.]

PANEL CONSISTING OF JASON WYASKET, NORTHERN UTE TRIBE, FORT DUCHESNE, UT, ACCOMPANIED BY KELLY BLISS AND STACEY JAMES, WASHOE TRIBE OF NEVADA AND CALIFORNIA; AND KENNETH GRANT, MISSISSIPPI CHOCTAW TRIBE, ACCOMPANIED BY RAENELL HOCKETT AND GILBERT THOMPSON

Mr. WYASKET. First I would like to say my name is Jason Wyasket. I am a member of the youth committee representing the Ute Indian Tribe of the Uintah and Ouray Reservation, Utah.

It has been our observation that at the Uintah and Ouray Reservation there is a great need for this bill and the need for this bill is because of several reasons. First of all, I feel that the Indian people as a whole could probably do a lot toward solving this problem for themselves except that the Indian people have traditionally needed to be pushed; and I feel that if this bill were to be passed it would sort of like provide a great stepping stone and would create the opportunity to start helping themselves towards doing what needs to be done to solve this problem.

And it has been our observation that during this tie we have been doing some research throughout the reservation and trying to find out exactly why there has not really been any opportunities to be presented to the youth of the tribe, and a lot of it has been because they feel that nobody really cares, I guess you can say, but we have been talking to people and then the parents, we have been talking to the parents, and they say they care but they really do not know how to communicate with their children, their sons and daughters.

And if this bill were to be passed, it would provide a lot of education and programs to help show these parents of the kids exactly what they need to say to them to help them have a better communication on this problem and it would solve a lot of problems.

Also the counselors have to be very skilled and trained adults and this training cannot be—in your bill it says kindergarten through the 12th grade. I feel it has to go beyond the 12th grade and start at an earlier age, in maybe a Headstart program or something like that because a lot of it, if you do not do it right away—it has been from the people of the tribe there—if you do not start right away it can be bad.

About 1 week ago I was riding home and there was a kid, probably no older than 4 or 5 years old, and he saw this other kid who had a glass of apple juice and he said, "What is this? Is that your brew?" You know, it has to start earlier, and everybody has to be involved with this, you know.

In our written statement that we have presented I have some suggestions made on parts of the bill that need to be changed. This part right here, I think it was section 203—this is referring back to section 315 of the Adult Education Act. I quote, "to provide alcohol and drug abuse counseling services to better enable Indians in need of such services"—wait. I messed up. I am sorry. I am quoting the wrong part.

Here it is: "Schools providing programs of instruction under subsection (a) are encouraged to emphasize family participation in such instruction."

You know, that is just encouragement. You can just say we would like you to come. That is encouragement. We feel that family participation is needed, and it should read something like this: "Schools providing programs of instruction under subsection (a) are required to have family participation whenever possible."

Now, that would read better for a lot of reasons. First of all, that would enable the parents to be able to get involved, and it would not really give them an excuse like I have bowling tonight, because that is one of the main things to do in the tribe, because there are tribal bowling leagues, and they use this a lot of times as an excuse.

And it just does not work that way. It should not work that way.

A lot of time a lot of kids who are arrested are just sent to jail for driving under the influence and stuff like that. There is a section in your bill which requires that they be sent to rehabilitation centers, and we have looked that over and we felt that would be a very good thing to have because of the fact that, first of all, when you go to jail you talk to a lot of people who have been around and they say, yeah, drugs and drinking is cool, you know, they are just trying to make the little kids think that way because the older Indian folks, a lot of them feel that way, that, you know, they are trying to sort of like be a role model but it is in the wrong way.

If they were sent to rehabilitation facilities and they were to be with their own age group, we feel there would be a rehabilitation process; and if there was followup, then it would provide great rehabilitation processes and would help the overall outlook and it would help especially with the followup care, help them to stay off the drugs and alcohol, and we feel that would be very good.

On the Uintah and Ouray Reservation we did a small study before we came and it was determined that approximately 95 percent of everyone on the reservation was involved with alcohol; either they lived with someone who had been drinking or else they knew somebody or they had done it themselves. And we feel that if this bill was passed it would cut down that number and it would be just a lot better for the Indian people, and it would help provide jobs and stuff because if you do not have people drinking, you have the ability to go to work, to earn money and get money flowing through the system; and we feel that would be a great stepping stone in the right direction, and I would like to thank the committee for providing this time to express my views on this bill. Thanks.

Mr. KILDEE. Thank you very much.

I want to put for the record too from the Mississippi Choctaw Tribe we have three witnesses: Raenell Hockett, Kenneth Grant who will testify next, and Gilbert Thompson.

Kenneth, thank you very much for your testimony.

Mr. GRANT. Mr. Chairman, my name is Kenneth Grant, and with this official written testimony I would like to add as the Mississippi Choctaw Indians we give our wholehearted support to passing the bill to help stamp out the negatives of alcohol and drug abuse as to allow the Indian youth to pursue the goals and the dreams and their lives; and I and our tribe would really like to see this bill be passed because I feel that it would make a lot of changes on the reservation and help control the drugs and alcohol abuse.

Mr. **Kildee**. Thank you, Kenneth. Do you attend public school, local public school?

Mr. **Grant**. I attend the Choctaw Central High School on the reservation.

Mr. **Kildee**. A BIA school on the reservation.

Raenell, you also attend——

Ms. **Hockett**. I am a college student attending Mississippi State University.

Mr. **Kildee**. Where did you attend high school?

Ms. **Hockett**. I attended the Choctaw Central High School on the reservation.

Mr. **Kildee**. Gilbert, are you attending the same high school?

Mr. **Thompson**. No, sir. I attended a public school in Philadelphia, Mississippi and I completed my course work in business administration at the University of Mississippi.

Mr. **Kildee**. Now, you live on the reservation or do you live off?

Mr. **Thompson**. I live on the reservation. I am employed with one of the enterprises that we managed to capture on the reservation.

Mr. **Kildee**. On the reservation school, you find a problem with drugs and alcoholism that this bill will help address?

Mr. **Grant**. Yes, sir.

Mr. **Kildee**. What percentage would you—we do not have precise figures; often it is a guesstimate. But what percentage of students at the school do you think are, regular users of drugs?

Mr. **Grant**. I would say 60 percent.

Mr. **Kildee**. That includes alcohol?

Mr. **Grant**. Yes.

Mr. **Kildee**. Do you feel that also, Raenell?

Ms. **Hockett**. I feel it is more alcohol related. There is not as much drugs. We do not have much of a problem with drugs. The main factor is alcohol and something needs to be done.

Mr. **Kildee**. Alcohol is our most abused substance in this country.

Ms. **Hockett**. There is easier access to it.

Mr. **Kildee**. Stacey and Kelly, you are from the Washoe Tribe. Where do you attend school?

Ms. **Bliss**. I attend the public school.

Ms. **James**. So do I.

Mr. **Kildee**. What kind of problem do you find with drugs and alcohol abuse at public school?

Ms. **Bliss**. That the high percentage was alcohol.

Mr. **Kildee**. You concur with that figure?

Ms. **James**. Yes, I do.

Mr. **Kildee**. What percentage of the student body at the public school are members of the tribe roughly?

Ms. **Bliss**. In my school I would say about 8 percent.

Mr. **Kildee**. So the majority are not members of the tribe?

Ms. **Bliss**. No.

Mr. **Kildee**. You find the problem of drug abuse among the non-Indians also high there in that school?

Ms. **Bliss**. Yes, very high.

Mr. **Kildee**. So it transcends the background of the person.

Ms. **Bliss**. Yes.

Mr. **Kildee**. Does that public school have the type of drug or alcohol program to help the students?

Ms. **Bliss**. Not that I heard of.

Ms. **James**. We do at our school. If you are an athlete and you are caught drinking, you sign a contract and they send you to these meetings for a week that you have to go to. It is a group, just a group of kids, and you talk about your problem and why you did it, stuff like that, and we have a SADD chapter which is Students Against Drunk Driving which the students just started because of the death of our friend, and we are starting Safe Ride; and that is when you call anybody—if you are drinking, you call the safe rider and they will bring you home so you do not have to drink and drive. But it is still not resolving the problem of alcohol. It is just——

Mr. **Kildee**. Gilbert, through the testimony you people mentioned in addition to this bill and along with this bill that we need to look at education opportunities, we need to look at job opportunities, recreation and also it was mentioned earlier that alienation from one's culture is part of the problem. Do you find that in your area? Could we do a better job in working with the Indian tribes and Indian Nations in this country to help them maintain their cultural ties? Do you think that would help generally in this particular problem?

Mr. **Thompson**. Being an Indian, you live in two types of worlds. You try to manage yourself in the modern, everyday world, learning English and also living with your heritage as an Indian; and many of the ideals do not flow over to the Indian side. And some of the basic dreams and ideals of parents, of normal everyday Americans, do not flow over, going to college, finding a good job as a doctor. We are finding that the enrollment of students from our area is decreasing into colleges, and so that economic things that we have done on our reservation—our most valuable resource is our youth; and if the enrollment of technical education is not there, where do we find our resources but off the reservation. And one of the reasons we wanted to get the enterprises there was to increase the economic level on the reservations; and when we have to go outside to employ, that just makes the per capita income lower.

Mr. **Kildee**. Jason, what level of school, what grade are you in?

Mr. **Wyasket**. I am a junior in high school.

Mr. **Kildee**. Do you plan to go to college yourself?

Mr. **Wyasket**. Yes, I do.

Mr. **Kildee**. What percentage of the student body do you think will be going to college from that school?

Mr. **Wyasket**. Approximately 60 percent.

Mr. **Kildee**. Sixty percent will be going to college.

Mr. **Wyasket**. They will try to go to college; let's put it that way.

Mr. **Kildee**. They would like to go to college.

Mr. **Wyasket**. Yes.

Mr. **Kildee**. Kenneth, what grade level are you in school?

Mr. **Grant**. Senior this year.

Mr. **Kildee**. Do you plan to go to college also?

Mr. **Grant**. Yes.

Mr. **Kildee**. What percentage of your school is planning to go on to college, rough estimate?

Mr. **Grant**. Maybe 40 percent.

Mr. **Kildee**. Now, you are at Mississippi State.

Ms. **Hockett**. Yes.

Mr. **Kildee**. Would most of them be going to Mississippi State or various colleges in the State or country?

Mr. **Grant**. They are probably going to junior college.

Mr. **Kildee**. We have what we call a tribal controlled junior community college legislation. Do you have a junior college serving the Choctaw? Do you have your own community college or do you go to the regional local community colleges?

Mr. **Grant**. Local.

Mr. **Kildee**. I want to thank this panel also. Do you have anything to add? You can sum up if you want. Do you have anything to add for the record? Your entire written testimony will be made part of the record. We will be printing up the record. You were very helpful to the committee because our bills are not written on Mt. Sinai; they are written on Capitol Hill.

And, Jason, you made some suggestion for amendments and that is very helpful to us. We appreciate that. Keep in contact with us on this. You are good resource people for us. We in Washington can live in an island; and unless we have contact with people out there who are really involved, our legislation will not really reflect the needs out there.

So this hearing has been very, very helpful to us. I think we will keep the record open for 30 days for any additional testimony you may wish to submit, and at that, with the thanks of this committee, the committee and the hearing will stand adjourned.

[Whereupon, at 12:50 p.m., the committee was adjourned.]

APPENDIX I

THURSDAY, OCTOBER 24, 1985

ADDITIONAL MATERIAL SUBMITTED FOR THE HEARING RECORD

HONORABLE JOHN MCCAIN
OF ARIZONA
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
OCTOBER 24, 1985

MR. CHAIRMAN, THIS COMMITTEE HAS TAKEN GREAT STEPS TO PUBLICIZE THE EXTENT OF THE EXISTENCE OF DRUG AND ALCOHOL ABUSE AMONG INDIAN JUVENILES.

I BELIEVE THAT THE WITNESSES TODAY WILL PROVIDE THE COMMITTEE WITH THE INFORMATION AND IDEAS NECESSARY TO MOVE LEGISLATION THAT WILL ACTUALLY HELP OUR YOUNG INDIANS.

I WOULD LIKE TO COMMEND CHAIRMAN UDALL FOR SCHEDULING THE SERIES OF FIELD HEARINGS, THIS PAST SUMMER IN RAPID CITY, SOUTH DAKOTA; ALBUQUERQUE, NEW MEXICO AND IN MY HOME STATE IN PHOENIX, ARIZONA AND FOR THE HEARING TODAY.

THE PROBLEMS AMONG OUR AMERICAN NATIVES ARE PERVASIVE WITH HIGH UNEMPLOYMENT, POOR HOUSING, INADEQUATE HEALTH CARE AND THE PERCEPTION OF LITTLE OR NO FUTURE ON THE RESERVATION. UNFORTUNATELY, TOO MANY OF OUR INDIAN YOUTH RESORT TO DRUG AND ALCOHOL ABUSE. I AM NOT JUST TALKING ABOUT THE BEER BLAST OR THE SMOKING OF MARIJUANA--BUT OF EVEN MORE TERRIBLE ABUSE. ON SOME POOR RESERVATIONS WHERE THE "HOLLYWOOD' GLAMOUR DRUGS LIKE COCAINE DO NOT EXIST, SOME INDIAN YOUTH RESORT TO "HUFFING GASOLINE",DRINKING STERNO AND EVEN INHALING HOUSEHOLD ITEMS SUCH AS LYSOL AND HAIR SPRAY.

ACROSS THE NATION, ON AND NEAR RESERVATIONS, EVEN HERE IN ARIZONA, THE PROBLEMS OF DRUG AND ALCOHOL ABUSE SHOULD BE LABELED EPIDEMIC. BECAUSE OF THIS I HAVE INTRODUCED ONE OF THE PIECES OF LEGISLATION BEFORE THE COMMITTEE TODAY (H.R. 2624). I COMMEND MY COLLEAGUE, MR. BEREUTER FROM NEBRASKA, FOR INTRODUCING H.R. 1156. BOTH BILLS ARE DIRECTED AT BEGINNING TO ADDRESS THIS PROBLEM THROUGH COOPERATION, EDUCATION AND COUNSELING WITH A GOAL TOWARD PREVENTION.

IT IS A COMPLEX PROBLEM WITHOUT EASY ANSWERS--WE CANNOT JUST APPROPRIATE MONEY AND WISH THE PROBLEM AWAY. HOWEVER, WITH THE COORDINATED DEDICATION OF LOCAL LEADERSHIP, WE CAN BEGIN DOWN THE RIGHT PATH. AND WE MUST NOT FORGET TO CONSIDER THE FAMILIES OF THOSE JUVENILE VICTIMS OF THE DISEASE. A STRONG FAMILY STRUCTURE WILL AID IN THE TREATMENT OF DRUG AND ALCOHOL ABUSE.

IN H.R. 2624, I PROPOSE THAT TO THE GREATEST EXTENT POSSIBLE DRUG AND ALCOHOL ABUSE PROGRAMS BE PLACED IN LOCAL CONTROL. TRIBAL GOVERNMENTS OR ENTITIES WITHIN THE TRIBES KNOW MUCH BETTER THE EXTENT OF THE PROBLEM AND HAVE AN UNDERSTANDING OF THE INTERRELATIONSHIP BETWEEN THE ABUSE AND EXISTING TRIBAL PROBLEMS.

HOWEVER, SINCE THIS IS A NATIONAL PROBLEM WITH OVERLAPPING CAUSES, I ALSO PROPOSE THAT EXISTING AND NEW FEDERAL PROGRAMS BE BETTER COORDINATED AND FOCUSED. I DO NOT WISH TO CREATE A VAST NEW BUREAUCRACY, WHICH EAT UP SCARCE DOLLARS. PROGRAMS EXIST IN THE DEPARTMENTS OF THE INTERIOR, OF EDUCATION, AND ESPECIALLY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITHOUT A COORDINATED EFFORT, DUPLICATION AND CONFLICTING SOLUTIONS CAN NEGATE SOME OF OUR BEST EFFORTS.

I BELIEVE THAT EDUCATION IS AN IMPORTANT ELEMENT TO A PREVENTION PROGRAM. IT MAY NOT BE THE ANSWER TO THOSE ALREADY RACKED BY THE DISEASE BUT IT CAN GO A LONG WAY TOWARD PREVENTING MANY OF OUR YOUTH FROM EXPERIMENTING WITH OR ABUSING DANGEROUS DRUGS, INHALANTS, OR ALCOHOL.

IN ADDITION TO SEARCHING FOR PREVENTIVE SOLUTIONS TO THE ABUSE--THROUGH EDUCATION AND COUNSELING--I RECOGNIZE THAT ON MANY RESERVATIONS A CRISIS HAS DEVELOPED. IN MY LEGISLATION, THE SECRETARY OF HHS WOULD BE DIRECTED TO IDENTIFY THESE CRISIS AREAS, COORDINATE THE MANY PROGRAMS WITH IN HHS, AND CONCENTRATE THE AVAILABLE RESOURCES IN THE CRISIS AREAS TO COMBAT THE DISEASE. I AM NOT TALKING ONLY ABOUT THE RESOURCES OF THE INDIAN HEALTH SERVICE, BUT FROM THROUGHOUT THE HHS. THE EXPERTISE IN THE HHS ABOUT THIS DISEASE IS IN THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION. I UNDERSTAND THAT THE OFFICIALS AT THE DHSS DO NOT SUPPORT THE CREATION OF A COORDINATING OFFICE AS FOUND IN H.R. 2624. I AM HOPEFUL THAT THOSE OFFICIALS WILL PROVIDE US WITH ASSURANCES THAT COORDINATION WILL EXIST BETWEEN THE DIFFERENT AGENCIES IN DHSS.

IT IS MY HOPE THAT THE EXPERTISE ALREADY EXISTING CAN BE QUICKLY FOCUSED ON THE INDIAN YOUTH DRUG AND ALCOHOL ABUSE PROBLEM. THE KEY TO LONG-TERM SUCCESS IS WITH THE YOUNG PEOPLE OF THIS COUNTRY. DRUG AND ALCOHOL ABUSE AFFECTS ALL OUR NATION'S YOUNG PEOPLE -- WHETHER THEY ARE INDIAN, BLACK, WHITE, POOR OR EVEN ADVANTAGED. WE MUST DO WHAT WE CAN TO DEVELOP THE OPPORTUNITIES OF ALL OUR PEOPLE THROUGH OUR MOST PRECIOUS RESOURCE--OUR YOUNG PEOPLE.

I REALIZE THAT MANY GOOD IDEAS EXIST ABOUT HOW TO ADDRESS THE PROBLEM FROM THE ASPECT OF A FEDERAL RESPONSIBILITY. A FULL EXAMINATION IS NECESSARY OF ALL IDEAS, SO THAT WE, AS LEGISLATORS, ENACT SOMETHING TO ACTUALLY HELP OUR INDIAN YOUTH AND NOT JUST EXPAND BUREAUCRACIES. IT IS MY HOPE THAT A CONSENSUS HAS FORMED ON THE BEST SOLUTION TO HELP OUR INDIAN YOUTH.

I HAVE BEEN ENCOURAGED RECENTLY ABOUT THE COMMITMENT OF DHSS TO ADDRESSING THIS PROBLEM. ON JULY 29 OF THIS YEAR, SECRETARY HECKLER WROTE TO ME AND THE MEMBERS OF THE REPUBLICAN TASK FORCE ON INDIAN AFFAIRS ABOUT INDIAN JUVENILE SUBSTANCE ABUSE. I WOULD LIKE TO OFFER THAT LETTER FOR THE RECORD. I AM HOPEFUL THAT THE WITNESSES FROM DHSS WILL EXPAND UPON THE COMMITMENTS IN THE JULY 29 LETTER.

THANK YOU, MR. CHAIRMAN.

Testimony by the Honorable Doug Bereuter
before the House Interior and Insular Affairs Committee
H.R. 1156, the Indian Juvenile Alcohol and Drug Abuse Prevention Act
October 24, 1985

Mr. Chairman, Members of the Committee, and Friends. It is always a pleasure to return to testify before this Committee, and a pleasure to see former colleagues. Today I am here to talk about a matter that is very important to me as well as to hundreds of thousands of young Indian children growing up in a difficult and challenging world. I am here to talk about the pervasive problem of alcohol and drug dependency that occurs far too much on reservations and in Indian communities across the United States.

For several decades, researchers have been investigating the use and consequences of alcohol and drug abuse among Native Americans. Inevitably, stereotypes developed about Indian drinking patterns, although it is important to note that the phenomenon began with the introduction of alcohol by early European explorers. Not only did they bring horses, guns, and tools for trading purposes, but they brought whiskey as well. While clearly the reasons leading to such high rates of alcohol and drug abuse among Indian people are complex, most Indian and non-Indian researchers alike point to joblessness, dislocation from tribal homelands, a decline in the importance of traditional cultural and religious influences, and increased external stresses on the family unit as being among the major causes of alcohol and drug abuse. Obviously, something needed to be done.

As a result, in November of 1983, my colleague from South Dakota, Mr. Daschle, and I began discussing the extensive problems of alcohol and drug abuse that we had observed among Indian youth on reservations in our own states and across the nation. Working closely with the Interior Committee, we drafted a bill that we introduced late in the 98th Congress as a discussion draft, H.R. 6196, the Indian Juvenile Alcohol and Drug Abuse Prevention Act. We then mailed this legislation for discussion to some 700 Indian tribal leaders, health and education specialists and policy makers throughout the United States, soliciting their suggestions and opinions. As a result of the hundreds of responses we received, we redrafted the measure and reintroduced it in this Congress, where it is known as H.R. 1156. In this regard, I would take this opportunity to express, on the record, my tremendous appreciation for all the comments, tribal resolutions of support, and helpful suggestions that we received from Indian people from all corners of Indian country and urban areas - from Alaska to the Carolinas. Without their very concrete assistance, we could not have produced the legislation that we are considering here today.

The great response from Indian people was not really a surprise. After all, tribal leaders have been telling Congress for sometime that alcohol and drug abuse is one of the greatest, and perhaps the greatest, health and social problem found on reservations today. Recognizing the urgency of the problem, Members of the Senate were also stimulated to offer legislation. Senator Mark Andrews of North Dakota and a bipartisan group of cosponsors introduced companion legislation and have held one hearing in this city. Tomorrow they are conducting their final hearing in Anchorage, Alaska. My sincere thanks to my Senate counterparts for their swift response.

Finally, I want to thank the Bureau of Indian Affairs and Indian Health Service for their actions in response to Congressional interest. While, candidly, we do not believe that their actions go far enough nor that they are sufficiently comprehensive, we have known and can see that they too share our concerns and the concerns of Indian people everywhere. We certainly agree that the insidious and devastating hold of alcohol and drugs on Indian young people must be stopped.

And now I wish to turn to the substance of my testimony. Naturally, I believe that all of the provisions of this bill are important, but today I am going to focus on those items that I believe to be of special importance.

The first matter I will address is what I mean by "program of instruction," a term used in Section 204 on page 5 of the bill. The bill would require Bureau of Indian Affairs schools and Bureau contract schools to offer "programs of instruction" in alcohol and drug abuse prevention from kindergarten through 12th grades. The legislation would encourage public schools that serve Indian children to do the same. The point here is that we want alcohol and drug abuse prevention and education to be a regular, consistent part of the academic program, interwoven where appropriate into health and physical education programs or history programs or science or creative writing classes. The limits of teachers' imaginations are the only limits to the ways that prevention can be taught. Moreover, I specifically reject a one-hour, audio-visual presentation, for example, an occasional evening lecture for families and young people, or information posted on the school bulletin board as meeting the definitions or intent I have in using the phrase "program of instruction." Neither do I believe it is acceptable to have critical drug and alcohol prevention programs subject to the vagueries of yearly funding competitions or the shifting priorities of administrators or teachers. We have heard too many stories of tribes with drug and alcohol prevention programs well underway who lose funding in subsequent years. Providing this critical kind of integrated educational offering in the classroom setting is the best way to guard against the uneven funding patterns of competitive projects or emphases.

There is another education-related matter that I wish to discuss, Mr. Chairman. Our bill, H.R. 1156, makes provision to reach Indian young children in public schools by expanding the Indian Education Act (Title IV). I believe that meeting drug and alcohol prevention needs for Indian youth would be incomplete if urban Indian adolescents were not included in our efforts or concerns. After all, 50% of Indian people now live in urban areas. In addition, there are some areas where nearly all Indian children on a reservation attend public school. This is the case in my Congressional District, the First District of Nebraska. Nearly all of the children of the Santee Sioux, the Omaha, and the Winnebago Tribes of Nebraska are served by public schools. I would be disappointed if my effort to combat alcohol and drug abuse among Indian youth did not benefit my own constituents. Thus, we revised Part A of the Indian Education Act to include as eligible activities alcohol and drug abuse counseling. We also specified that Part C monies would be made available to urban Indian centers for the training of alcohol and drug abuse counselors. When the use of Title IV provisions - which fund culturally relevant programs under the Indian Education Act - are inadequate to help an Indian child in the public school setting, Part C monies that can be used to train counselors in Indian centers become particularly important. Experts have advised us that often times the Indian center provides a more secure, culturally relevant setting for such young people. Therefore, the role of Indian centers in this effort is a crucial one. They, and the public schools, will provide the necessary and vital leadership needed in urban Indian communities in the fight against alcohol and drug abuse.

Finally, Mr. Chairman, I want to share with the Committee an experience I had at a public school on one of the reservations in my district. The impact of that visit has provided me with a constant source of deep concern and resultant commitment to this legislation. Some time ago I spent an afternoon at a school that has a Fetal Alcohol Syndrome program run by the Carl T. Curtis Health Education Center in conjunction with the Omaha Tribe. Fetal Alcohol Syndrome, as most of my colleagues know, is caused by excessive drinking during pregnancy. The most common manifestations of the syndrome are varying degrees of mental retardation, facial abnormalities and abnormalities to the extremities, and reduced birth weight and length, as well as lifelong growth deficiencies. Fetal Alcohol Effect is a less devastating result of maternal drinking. The tragic consequences of Fetal Alcohol Syndrome, and ensuing terrible waste of human lives, can be totally prevented if the mother abstains from alcohol consumption during pregnancy. But without pre-natal counseling about the effects of alcohol on the growth and development of the fetus, many young mothers will never know what their drinking is doing to their unborn babies.

There is nothing more precious than the health and well-being of a community's youth, Mr. Chairman. Young people who have their health, their pride, and sense of self-worth will grow up to make the changes and meet the challenges that are necessary to any society's growth and survival. I suggest that the existence of strong, culturally viable, proud and self-sufficient American Indian communities within our midst enriches the lives of all Americans and reaffirms our dedication to a pluralistic society. I firmly believe that this legislation is a necessary component in the effort to achieve that goal.

In closing, Mr. Chairman, I request permission to submit for the hearing record the letters of official comment that we have received regarding H.R. 6196, and now H.R. 1156. I believe that these letters will form an important addendum to the hearing record. I thank you for your time, your interest and support, and welcome any questions.

STATEMENT OF CONGRESSMAN TOM DASCHLE
BEFORE THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
ON THE INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT
THURSDAY, OCTOBER 24, 1985

Alcohol and drug abuse among Native Americans, especially among Indian youth, remains a devastating and debilitating problem on reservations in my home state of South Dakota and across the country.

Without question, alcoholism and drug abuse is the number one social and health problem among Native Americans. The 1980 Census shows that the alcoholism rate for Indians is 451% higher than the rest of the United States population. Alcohol-related death and disease are the biggest killers on the reservation, nearly eight times greater than that of the non-Indian community. The impact of substance abuse in the Indian community is revealed in statistics directly related to trouble with the law, a high rate of suicide, and disruption of family life.

These troubles have unfortunately but unquestionably been passed along to the younger generation of Native Americans. Indian children are drinking alcohol frequently by age 13, studies show, and the use of marijuana and inhalants like Lysol, paint thinner, and antifreeze is beginning at earlier ages and occurring more often. One study conducted among 4th, 5th, and 6th graders on the Pine Ridge Indian Reservation shows that as many as 35 per cent of elementary schoolchildren have experimented with or continue to use alcohol. We can no longer deny that a crisis exists; furthermore, we can no longer afford to sit back and hope that this problem will solve itself. It has not done so in the past and it simply will not resolve itself in the future.

That is why Congressman Doug Bereuter and I are here today: to continue to plead the case for the Indian Juvenile Alcohol and Drug Abuse Prevention Act. We saw a real need for this legislation two years ago. In 1983 we began to develop legislation which would focus not just on the causes of the Indian youth substance abuse problem, but would provide educational programs about its dangers and would identify problem cases and establish counseling and treatment programs as well.

The Indian Juvenile Alcohol bill is an improved version of legislation Congressman Bereuter and I introduced in the 98th Congress. Throughout the development of this measure, we consulted over 700 Indian leaders and health professionals, both groups and individuals, in order to receive their suggestions and valuable insight. The legislation that is being discussed in the Interior Committee hearing today reflects information and ideas gathered from and presented by a wide range of authoritative sources, from agencies here in Washington to local tribal members who have personally witnessed the tragedies caused by alcohol and drug abuse on the reservation.

There has been bipartisan support in the House for this legislation since it was originally introduced, and that strong support is still evident on both sides of the aisle today. A companion bill is being considered in the Senate and also enjoys bipartisan support. An issue like this, a desperately-needed attempt to improve lives, to save lives, supercedes any other political concerns. Numerous hearings have been held across the country in the past two years on the Indian Juvenile Alcohol bill, and it is unanimously acknowledged that we must act on it now, before yet another generation of Native Americans is ravaged by this problem.

Congressional action on the Indian Juvenile Alcohol bill is essential because of the current Administration's lack of attention and effort toward the Indians juvenile substance abuse problem. While officials of the Bureau of Indian Affairs and the Indian Health Service admit that alcohol and drug abuse is the most serious social and health problem facing Indian people, IHS has directed only one percent of its budget toward the combined area of drug and alcohol abuse. Such a lack of resources, a lack of response, a lack of initiative applied to the drug and alcohol problem clearly proves it is not a priority.

They claim that sufficient funding and adequate programs are already in place to deal with alcohol and drug abuse. I believe that such claims are unfounded and that they present an attitude of insensitivity and apathy toward the needs that really exist on a local level. BIA and contract schools on most reservations are lacking in comprehensive, or even minimal, programs to address the abuse problem.

The schools are our greatest hope for attacking the problem of alcohol and drug abuse. A preventive approach is the underlying premise of the Indian Juvenile Alcohol bill, which provides training for teachers as well as educational and instructional programs and other structured activities for students. If we can reach Indian students at an early age and make them aware of the dangers of substance abuse, we have an important opportunity to prevent their involvement with the problems I mentioned earlier in my testimony.

I hear repeated complaints of an absence of coordination between the Bureau of Indian Affairs and the Indian Health Service, and I understand that there are seldom any attempts on their part to involve local tribal governments in policy and program decisions. Other reports I receive from Indian leaders in South Dakota indicate that there is a serious lack of quality evaluations, monitoring, and direction in the few programs which do presently exist. Title I of the Indian Juvenile Alcohol bill would require the BIA and IHS to coordinate their efforts and resources and to periodically review their joint progress.

One of these few successful programs is Project Phoenix, a residential treatment center for Native American youth, located on the Pine Ridge Indian Reservation. It is operated on a contract basis with the Indian Health Service.

While Project Phoenix has made a significant contribution in the past five years in helping hundreds of young Indians salvage their lives from the danger of serious alcohol and drug abuse problems, there are thousands more who still need help. Each month the Project must turn away dozens of potential clients because of a lack of space and unsafe facilities. IHS training programs are infrequent and can create financial, transportation, and scheduling difficulties for counselors. Project Phoenix has a number of problems and needs that must be addressed. Title V of the Indian Juvenile Alcohol bill would ease these problems by directing the BIA and IHS to study thoroughly the extent of the drug and alcohol problem then would provide treatment services such as detoxification, counseling, and follow-up care.

The Indian Juvenile Alcohol and Drug Abuse Prevention Act would not only supplement and strengthen Project Phoenix, but it would improve the relatively few existing services and develop new preventive and educational programs in the schools. These changes and additions are desperately needed by the Indian population. I strongly urge the Members of the Committee to act swiftly and judiciously to report the Indian Juvenile Alcohol and Drug Abuse Prevention Act for consideration by the full House.

Thank you.

STATEMENT OF HAZEL ELBERT, ACTING DEPUTY ASSISTANT SECRETARY FOR INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, BEFORE THE HEARING OF THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS, U.S. HOUSE OF REPRESENTATIVES, ON H.R. 1156, A BILL "TO COORDINATE AND EXPAND SERVICES FOR THE PREVENTION, IDENTIFICATION, TREATMENT, AND FOLLOW-UP CARE OF ALCOHOL AND DRUG ABUSE AMONG INDIAN YOUTH, AND FOR OTHER PURPOSES"; AND H.R. 2624, A BILL "TO AUTHORIZE PROGRAMS FOR THE TREATMENT AND PREVENTION OF DRUG AND ALCOHOL ABUSE AMONG INDIAN JUVENILES."

October 24, 1985

Good morning Mr. Chairman and Members of the Committee. I am pleased to be here today to present the views of the Department of the Interior on H.R. 1156 and H.R. 2624 which deal with the prevention, identification, and treatment of alcohol and drug abuse among Indian youth.

We consider alcohol and drug abuse to be the most serious social and health problem facing Indian people today. Our statistics show that the majority of BIA and tribal arrests involve alcohol and drug abuse and that many of these arrested are juveniles.

H.R. 1156 and H.R. 2624 attempt to address the critical problem of alcohol and drug abuse in Indian Country by requiring more coordination of information and services between the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS); training of all personnel working directly with Indian youth; a more comprehensive education program in BIA schools; alternative placements for children arrested for drug and alcohol-related offenses; and more comprehensive alcohol and drug abuse treatment centers which include detoxification facilities, counseling services, and follow-up care.

Although we support some of the concepts addressed in these bills, we oppose both bills as drafted. Our major concerns are as follows:

Title I of H.R. 1156 provides for extensive coordination of information and services between the BIA and the IHS. We agree there is a need for better coordination and we will be happy to pursue it. However, we believe that the Indian Health Service is better equipped to work with the tribes to identify services available to them in their immediate geographic area. Moreover, we question the need for formal tribe-by-tribe agreements to identify and coordinate services which would force assistance to be allocated on a first-come, first-served basis rather than to where the greatest need might exist.

H.R. 2624 provides for coordination of programs between BIA, IHS and the Department of Education and requires that an office be set up within the Alcohol, Drug Abuse and Mental Health Administration to administer the program. We defer to the Department of Health and Human Services (HHS) on this provision.

Both bills require that alcohol and drug abuse instructional programs be provided to all students in BIA and contract schools. We believe that this provision would be an appropriate replacement for the Indian school provisions in the Act of May 29, 1886 (24 Stat. 69; 20 U.S.C. 111, 112) which requires similar instruction.

We have 122 alcohol and drug abuse programs in place in our schools. Attached to my statement is a list of the programs. This school year these programs will be expanded and improved in connection with an interagency agreement with the Department of Justice under which we will receive $150,000 to be used for training school and dormitory staff in alcohol and drug abuse programs and for purchasing classroom materials. Our preliminary plans are to provide training to teachers from 48 schools in eight locations. This program will also provide materials to schools which can be used immediately by the teachers after they receive the training. This program will affect approximately ten thousand students.

In addition, five of our employees will receive training in Seattle and become trainers of a new in-house training cadre. The cadre will be used throughout the Bureau's education system to train other teachers and staff.

Title II of H.R. 1156 amends the Elementary and Assistance Act (20 U.S.C. 241cc), the Indian Education Act (20 U.S.C. 2285b) and the Adult Education Act (20 U.S.C. 1121a(a)) to provide for more training for teachers and counselors in the area of alcohol and drug abuse. We defer to the Department of Education on this provision.

Title II also requires BIA and contract schools to remain open during the summer months to provide recreation and counseling programs to Indian youth. This provision is unnecessary and requires the Bureau to provide programs that should be left to the Secretary's discretion. The need for such programs should be determined by the agency on the basis of need and availability of resources rather than by congressional mandate.

Finally, Title II requires the Bureau to publish a quarterly newsletter to report on Indian alcohol and drug abuse projects. We oppose this provision. This provision is unnecessary. The Bureau recently contracted with the Tom Clary Institute Inc. to publish and distribute a newsletter called "Linkages for Indian Child Welfare Programs." We propose expanding this newsletter to include topics on juvenile alcoholism and drug abuse. The first issue is scheduled to be published under the contract this month and the central article will discuss this very subject. We estimate that within existing resources, we could increase the number of pages of this publication 25 percent (4 pages) as well as double the number of issues distributed.

This approach would be much less costly than initiating a new publication and could be done immediately without additional appropriations.

Both bills require the IHS to provide training for new community health representatives and aides. H.R. 2624 would also require the Secretary of HHS in cooperation with the Secretary of the Interior, to make appropriate alcohol and drug abuse training available to tribal and BIA staff. We defer to the IHS on this provision.

Title IV of H.R. 1156 authorizes the Secretary of the Interior to promulgate guidelines authorizing law enforcement officers to place juveniles arrested for offenses related to the abuse of alcohol and drugs in emergency shelters or a community-based treatment facility. We agree that where such facilities are available, law enforcement officers should have guidelines to assist them in determining proper placement of juveniles when they are apprehended.

Title IV of H.R. 1156 also requires the Secretary to establish temporary emergency shelters to house Indian juveniles apprehended for offenses relating to alcohol and drug abuse. We recognize the need for some kind of emergency shelter or facility to address the problem. However, we must assure that additional facilities, if any, are not duplicative of the existing networks of special care facilities and foster homes supported by the Indian Child Welfare Act grant program. Therefore, we believe that no special funding authority is presently needed to establish special new emergency shelters. In using any facilities, we would propose using State and tribal licensing requirements as we do under the Indian Child Welfare program. We do not support the concept of compensation to Indian families providing emergency shelters to those juveniles. The number of available families with adequate facilities to provide these services is limited in the reservation setting and if the juvenile is not provided with counseling or other necessary services the home simply provides a holding facility that in many cases would not be adequate to deal with the needs of the youth.

Both bills require the IHS to provide comprehensive alcohol and drug abuse treatment services including detoxification, counseling services and follow-up care in IHS facilities. We defer to the IHS on those provisions.

Title VI of H.R. 1156 provides a number of definitions which we find acceptable.

In summary, we applaud the Congress in attempting to address this very serious and complex problem but for the reasons outlined above, we oppose H.R. 1156 and H.R. 2624. However, we would be pleased to work with the Committee in addressing these problems.

This concludes my prepared statement. I will be happy to answer any questions the Committee may have.

ATTACHMENT A:

DESCRIPTIONS OF ALCOHOL AND DRUG PROGRAMS

The following is a brief description of the programs which are included in the report of Bureau funded schools that have Alcohol and Drug Abuse Programs.

1. "On the Right Track"/Navajo Alcohol Program

   "On the Right Track" was especially developed by the Navajo Tribe for implementation in schools which serve Navajo students. The program was "designed to reduce the risk factors of alcohol and drug substance abuse among school-age Navajo children." According to the program description, the program includes a full range of activities directed toward prevention. One of the activities is a "medically sound, culturally sensitive and appropriate alcohol and substance abuse education component to be incorporated into existing school-health education curriculum of the schools." The Navajo Alcohol Program was the predecessor of "On the Right Track."

2. Locally Developed Programs

   These are programs developed by the schools utilizing local resources and materials and which are designed to fulfill the needs of the school. The schools utilize training materials from PHS, IHS, Law Enforcement, Title IV, local expertise, state developed materials and curricula, materials developed by the tribes, etc. In addition, the agencies provide training for the school staff. These programs are not as comprehensive as "Project Charlie" or "On the Right Track," etc.

3. Indian Health Service

   These are programs in which Indian Health Service personnel render techni-assistance to local schools. The personnel conduct classes, make presentations, present video cassette programs, assist the local schools to develop relevant materials to incorporate into the curriculum. The IHS also provides training for the school staff.

4. "Project Charlie" and "Here's Looking at You, Two"

   These are two of the most popular alcohol and drug abuse programs that are being used both in the public and Bureau schools. They were developed by private organizations and are considered to be the most complete and all-encompassing programs available on the market. "Project Charlie" is for grades K - 6 and "Here's Looking at You, Two" is for grades K - 12.

5. Other

   The other programs mentioned in the report are programs and curricula developed by state departments of education, the Public Health Service, Indian Health Service, other federal agencies, and those that are a combination of these programs the content of which the schools have adapted to fulfill their specific needs. In addition, the agencies provide in-service training for the school staff.

ALCOHOL AND DRUG ABUSE PROGRAMS

Name of School	Description of Program	Contact Person
Laguna Agency		
1. Laguna Elementary School	"Project Charlie"	Lucinda Sanchez
Chinle Agency		
2. Cottonwood Day School	Navajo Alcohol Program	Peter P. Sandoval
3. Low Mountain Boarding School	Navajo Alcohol Program	Richard D. Simpson
4. Lukachukai Boarding School	Navajo Alcohol Program	Larry Tsosie
5. Nazlini Boarding School	Navajo Alcohol Program	Lorraine Etsitty
6. Pinon Boarding School	Navajo Alcohol Program	William H. Draper
7. Rock Point Community School	Navajo Alcohol Program	Benjamin Barney
8. Rough Rock Demonstration School	Navajo Alcohol Program	Jimmy C. Begay
9. Chinle Boarding School	Navajo Alcohol Program	Roland E. Kimbrough
10. Many Farms High School	Navajo Alcohol Program	Phillip Hardy
11. Black Mesa Community School	Navajo Alcohol Program	Dorothy R. Yazzie
Fort Defiance Agency		
12. Chuska/Tohatchi Consolidated Sch	"On the Right Track"	Helen Zongolowicz
13. Crystal Boarding School	"On the Right Track"	David S. Jones
14. Dilcon Boarding School	"On the Right Track"	Berlyn R. Yazzie
15. Greasewood Boarding School	"On the Right Track"	James R. Byrnes
16. Holbrook Dormitory	Peer Counseling Program	Grace P. Yazzie
17. Hunters Point Boarding School	"On the Right Track"	Roy H. Chase
18. Kinlichee Boarding School	"On the Right Track"	Vincent C.B[illegible]ch
19. Pine Springs Boarding School	"On the Right Track"	Lena R. Wilson
20. Seba Dalkai Boarding School	"On the Right Track"	Lula M. Stago
21. Snowflake Dormitory	Peer Counseling Program	Leonard Smith

Alcohol and Drug Abuse Programs (continued)

Name of School	Description of Program	Contact Person
22. Wide Ruins Boarding School	"On the Right Track"	Lena Mae Jim
23. Winslow Dormitory	Peer Counseling Program	Ernest Rivers
24. Toyei Boarding School	"On the Right Track"	Jill Lorah
Southern Pueblos Agency		
25. Sky City Community School	Locally Developed Program	Cyrus J. Chino
26. Isleta Elementary School	Locally Developed Program	Mary McBride
27. Jemez Day School	Locally Developed Program	Junita Complo
28. San Felipe Day School	Locally Developed Program	Edward Dolar
29. Zia Day School	Locally Developed Program	Gilbert Lucero
Eastern Area Office		
30. Ahfachkee Day School	Indian Health Service	Rondell Clay
31. Miccosukee Indian School	Indian Health Service	Maria Osceola-Branch
32. Indian Township School	Indian Health Service	Forrest Osgood
33. Beatrice Rafferty School	Indian Health Service	Sister Maureen Wallace
34. Indian Island School	Indian Health Service	Sister Helen McKeough
35. Cherokee Central School	Indian Health Service	John Wahnee
Hopi Agency		
36. Hopi Day School	Hopi Tribal Program	Martin A. Green
37. Muencopi Day School	Hopi Tribal Program	Elvira J. Pasena
Muskogee Area Office		
38. Sequoyah High School	Locally Developed Program	Nadine Givens
39. Carter Academy	Locally Developed Program	Delton Henry
40. Eufaula Dormitory	Locally Developed Program	Van McIntosh
41. Jones Academy	Locally Developed Program	Delton Cox

Alcohol and Drug Abuse Programs (continued)

Name of School	Description of Program	Contact Person
Portland Area Office		
42. Quileute Tribal School	Locally Developed Program	Stephen F. Vause
43. Coeur d'Alene Tribal School	Locally Developed Program	Don Beach
44. Chemawa Indian School	"Here's Looking at You, Two"	Gerald J. Gray
45. Lummi Tribal School	"Here's Looking at You, Two"	Russell Alway
46. Two Eagle School	Locally Developed Program	Richard E. Barber
Eastern Navajo Agency		
47. Baca Community School	Locally Developed Program	Hoskie Largo
48. Bread Springs Day School	Locally Developed Program	Jerry V. Collins
49. Chi Ch'il Tah Community School	Locally Developed Program	John L. Taylor
50. Huerfano Dormitory	Locally Developed Program	Daniel W. Fox
51. Jones Ranch Day School	Locally Developed Program	John L. Taylor
52. Lake Valley Navajo School	Locally Developed Program	David J. Atanasoff
53. Mariano Lake Community School	Locally Developed Program	Stanton D. Curtis
54. Ojo Encino Day School	Locally Developed Program	Richard Toledo
55. Pueblo Pintado Community School	Locally Developed Program	Clyde D. Kannon
56. Standing Rock Community School	Locally Developed Program	Tito Martinez
57. Dlo'Ay Azhi Community School	Locally Developed Program	Amy W. Mathis
58. Na'Neelzhiin Ji' Olta'	Locally Developed Program	Harvey D. Allinso
59. Wingate Elementary School	Locally Developed Program	Beverly J. Crawford
60. Wingate High School	Locally Developed Program	Jay Bruce Hoover
61. Crownpoint Communithy School	Locally Developed Program	Joe E. Frazier
62. Dzilth-na-o-dith-hle Comm Sch	Locally Developed Program	D. Duane Robinson
63. To'Hajiilee'He School	Locally Developed Program	?
64. Magdalena Dormitory	Locally Developed Program	John A. Blomquist

Alcohol and Drug Abuse Programs (continued)

Name of School	Description of Program	Contact Person
Western Navajo Agency		
65. Chilchinbeto Day School	Locally Developed Program	George Mitchell
66. Dennehotso Boarding School	Locally Developed Program	Irving Jones
67. Flagstaff Dormitory	Locally Developed Program	James Kimery
68. Kaibeto Boarding School	Locally Developed Program	Roland E. Smith
69. Leupp Boarding School	Locally Developed Program	Mark W. Sorensen
70. Navajo Mountain Boarding Sch	Locally Developed Program	Blanche M. Barrows
71. Red Lake Day School	Locally Developed Program	Ray L. Interpreter
72. Richfield Dormitory	Locally Developed Program	Kevin Skenadore
73. Rocky Ridge Boarding School	Locally Developed Program	Fredrick M. Johnson
74. Shonto Boarding School	Locally Developed Program	Lyle G. Elton
75. Tuba City Boarding School	Locally Developed Program	Jerry E. Diebel
76. Tuba City High School	Locally Developed Program	Andrew M. Tah
Aberdeen Area Office		
77. Theodore Jamerson Elem Sch	Locally Developed Program	Joan R. Estes
78. Flandreau Indian School	"Here's Looking at You, Two"	Berle Johnson
79. Wahpeton Indian Boarding Sch	Locally Developed Program	Leroy W. Chief
80. Pierre Indian Learning Center	Locally Developed Program	A. Gay Kingman
81. Marty Indian School	Locally Developed Program	Richard Christensen
Pine Ridge Agency		
82. Little Wound School	Locally Developed Program	Ray Phipps
83. Loneman Day School	Locally Developed Program	Duane Ross
84. Pine Ridge High School	Locally Developed Program	Benjamin B. Tyon
85. Porcupine Day School	Locally Developed Program	Marvin W. Waldner
86. Crazy Horse School	Locally Developed Program	Charles Mason

Alcohol and Drug Abuse Programs (continued)

Name of School	Description of Program	Contact Person
Cheyenne River Agency		
87. Bridger Day School	"Project Charlie"	Faye Longbrake
88. Cherry Creek Day School	"Project Charlie"	Faye Longbrake
89 White Horse Day School	"Project Charlie"	Asad Khan
90. Cheyenne-Eagle Butte School	"Here's Looking at You, Two"	Jerry Smith
Fort Berthold Agency		
91. White Shield School	Locally Developed Program	Ron Rauf
Rosebud Agency		
92. St. Francis Indian School	OE Region V Training Center	Roger C. Bordeaux
Sisseton Agency		
93. Enemy Swim Day School	Locally Developed Program	Cecil Phillips
Standing Rock Agency		
94. Bullhead Day School	OE Region V Training Center	Michael Donner
95. Little Eagle Day School	OE Region V Training Center	Adele F. Little Dog
96. Standing Rock Community Sch	OE Region V Training Center	Linda Lawrence
Turtle Mountain Agency		
97. Turtle Mountain Elem & Mid Sch	Locally Developed Program	Elener C. Monson
98. Turtle Mountain High School	Locally Developed Program	Ernesto Jimenez
Billings Area Office		
99. Labre Indian School	"Here's Looking at You, Two"	William D. Walker
100. Busby School	Locally Developed Program	Robert Bailey

Alcohol and Drug Abuse Programs (continued)

Name of School	Description of School	Contact Person
Phoenix Area Office		
101. Duckwater Shoshone Elem Sch	Locally Developed Program	Roberta Thompson
102. Phoenix Indian High School	Education & Prevention Prog	Richard T. Christman
103. Sherman Indian High School	NA Substance Abuse Council	Mahlon I. Marshall
104. Pyramid Lake High School	Locally Developed Program	Gordon V. Ruff
105. Salt River Day School	Gila River Alcohol Project	Farrell B. Whitey
Fort Apache Agency		
106. Cibecue Community School	Locally Developed Program	Gerald Knowles
107. Theodore Roosevelt School	Locally Developed Program	Leon W. Ben
Papago Agency		
108. Santa Rosa Ranch School	Locally Developed Program	Jean Tyson
109. Santa Rosa Boarding School	Locally Developed Program	Clyde V. Peacock
110. San Simon School	Locally Developed Program	Della B. Williams
Shiprock Agency		
111. Aztec Dormitory	Local Self-Help Center	Jack Nolan
112. Beclabito Day School	Locally Developed Program	Heber C. Black
113. Red Rock Day School	Locally Developed Program	Johnny C. Begay
114. Toadlena Boarding School	Locally Developed Program	Jeanne Hoskie
Albuquerque Area Office		
115. Santa Fe Indian School	Locally Developed Program	Joseph Abeyta, Jr.
Minneapolis Area Office		
116. Hannaville Boarding School	Locally Developed Program	Thomas C. Miller

Name of School	Description of Program	Contact Person
Choctaw Agency		
117. Chitimacha Day School	Louisiana Dept Of Educ	John E. Singleton
118. Red Water Day School	Locally Developed Program	William F. Bell
119. Tucker Day School	Mississippi Dept of Educ	John W. Brewer
120. Bogue Chitto Day School	Mississippi Dept of Educ	Dianne Cuchens
121. Conehatta Day School	Muskogee Health Proj Edition	Bruce Marlin
122. Choctaw Central School	Locally Developed Project	Calvin J. Isaac

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT ON H.R. 1156 and H.R. 2624

"INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT"

BY

ROBERT KREUZBURG, M.D.

ACTING DEPUTY DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS.

UNITED STATES

HOUSE OF REPRESENTATIVES

OCTOBER 24, 1985

Mr. Chairman and Members of the Committee:

I am Dr. Robert Kreuzburg, Acting Deputy Director of the Indian Health Service (IHS). With me is Dr. Craig Vanderwagen, Acting Director, Division of Clinical and Environmental Services, and Mr. Russell (Bud) Mason, Chief, Alcoholism Program Branch. I am very pleased to be here today to discuss with you and your Committee H.R. 1156 and H.R. 2624, bills to coordinate and expand services for the prevention, identification, treatment and follow-up care of alcohol and drug abuse among Indian youth. However, we oppose enactment of H.R. 1156 or H.R. 2624.

The Department of Health and Human Services (HHS) and the IHS certainly share the concern of the Committee and Indian communities regarding the serious problem of alcohol and drug abuse among American Indian/Alaska Native youth. IHS recognizes that the abuse of alcohol and drugs is the most serious health and social problem faced by Indian people. Alcohol abuse is frequently cited as a direct contributing factor in at least four of the top ten causes of death among Indian people, i.e., accidents, liver diseases, homicide, and suicide.

Empirical evidence indicates that this abuse is directly affecting a younger and younger population with grammar school aged children beginning the use of alcohol and abuse of such substances as Lysol, glue, paint and type correction fluid.

We share the goal of the Committee of decreasing drug and alcohol abuse among American Indians/Alaska Natives. Although we support many of the concepts addressed in H.R. 1156 and H.R. 2624 we have concerns regarding their implementation, and therefore we do not support the proposed bills as a means to achieve that goal.

Before turning to a discussion of the bills, I would like to present a brief background about substance abuse programs among the Indian and Alaska Native people and what the IHS is currently doing in this area.

By 1976, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was supporting over 160 American Indian and Alaska Natives administered and operated alcoholism treatment programs at an annual level in excess of $16 million. The NIAAA support of community treatment grants was limited by law and Institute policies to an initial three year project demonstration period and one three year renewal. Subsequently, support for the programs was to be the responsibility of State and local funding sources. However, it was the determination of the Congress, that the Indian alcoholism programs would not survive without continued Federal support. Consequently, the Congress directed the phased transfer of "mature" programs (i.e., programs which had received six years of Institute support) from the NIAAA to the IHS for continued long term support and provided the authority for this transfer in the Indian Health Care Improvement Act, P.L. 94-437. Funding to support Indian alcoholism programs has been a part of the IHS appropriation base since FY 1978.

In FY 1985, 219 substance abuse programs were supported by the IHS at an annual cost of $24.607 million. The 219 programs are funded by contracts between the IHS and a wide assortment of Indian tribes, tribal groups, bands and associations that provide substance abuse prevention/treatment services. The IHS encourages substance abuse prevention and promotion activities with programs under contract with the IHS. The services provided by the contractors vary from program to program. The Indian substance abuse programs offer an array of treatment and prevention services through one or more of the following components: detoxification, primary residential treatment, halfway houses, outpatient care, school-based prevention, community-based prevention, drop-in centers, outreach, and aftercare.

The substance abuse programs conduct prevention activities. Most Indian substance abuse programs provide presentations on substance abuse to youth groups in communities and reservations. The program staffs also work with the Indian leaders to provide promotion campaigns against excessive use of alcohol. They assist school and county government officials in identifying materials and resources that might change community values which reinforce alcoholism and alcoholic behavior.

In addition to programs contracted out to tribes and Indian associations, alcohol abuse prevention/treatment services are rendered through 48 IHS hospitals and over 200 clinics.

School based programs are also operating in several parts of the country. They promote students becoming actively involved in learning effective decision making skills, establishing a positive self-image and activities which help students develop life coping skills. These activities also emphasize campus-wide alcohol and drug abuse intervention programs. Another example is a vocational technical training center, which includes adult students, that is coordinated with a women's halfway house. Prevention activities are integrated into many Federal and State school systems in an effort to decrease the number of teenagers who get involved with alcohol or drugs.

Examples of primary prevention services being provided in outpatient treatment centers include: health education, motivational counseling, self-awareness, values clarification, traditional counseling by elders, decision making, developing coping skills, youth leadership, and life enhancing skills.

Several of these programs use role models very effectively. The use of puppets, charades and plays culturally designed for alcohol and drug education have proven to be very effective. There are a number of programs that have parent-youth groups, teenage pregnancy counseling, crisis intervention, and parenting skills education.

It should be noted that the majority of these programs have primarily targeted alcohol abuse. Congressional intent has been very clear in specifying this programmatic emphasis. Notwithstanding, alcohol abuse is part of the continuum of substance abuse and many current "alcohol program" activities have efficacy in dealing with all forms of substance abuse. Many of the local programs capitalize on this fact to provide broadly based substance abuse services. High risk youth can be characterized in several ways. They tend to have inadequate knowledge of available community alternative activities, poorly developed or inadequate life coping skills; they demonstrate little or no interest in available organized activities such as scouting, theater, dance groups, band or other after school groups. In response to these deficiencies, special programs provide enrichment activities, work with parents, and developed recreational activities.

The Department supports the intent of legislation which outlines a program aimed at arresting alcohol and drug abuse among Indian youth. Juvenile alcohol and drug abuse has reached epidemic proportions in many Indian communities. The problems are such that the sort of interagency cooperation called for in H.R. 1156 and H.R. 2624 is essential if meaningful success is to be achieved. In fact, we are already effecting this cooperation. There are working agreements between the Bureau of Indian Affairs (BIA) agency offices and IHS Service Units and between the IHS Service Units and local tribes in many locations. Also, since 1972 when 50 Office of Economic Opportunity funded Indian alcoholism programs were transferred to the NIAAA and an Indian Desk for Support and Liaison was established, a major funding policy was implemented which required all applicants to obtain memorandums of agreement and commitments from all applicable resource agencies in all local Indian communities. The requirement for these agreements has been continued following transfer of the alcoholism programs from the NIAAA to the IHS. They are an integral part of the management of local alcoholism programs and they effect considerable coordination between IHS and other interested parties and organizations. We believe, therefore, that new legislation is not needed to ensure such efforts.

We do oppose Sec. 2 of H.R. 2624 which would provide for statutory establishment of an Office of Indian Juvenile Alcohol and Drug Abuse with a mandatory organizational structure. The placement of administrative responsibility for program efforts and the establishment of an organizational structure for carrying those efforts forward are better handled by existing departmental management staff closest to the problem. We believe that those management staff know best how to channel funding and staff resources to obtain the most effective and efficient results.

In addition, we believe that H.R. 1156 and H.R. 2624 contain redundant authorities, call for activities at a national level which can more effectively and economically be done at the local level, would dissipate available resources by directing them into producing national reports and studies and away from services, and have unrealistic schedules for these reports.

The agreements between the Secretaries of the Interior and Health and Human Services called for in these bills demonstrate the above points. These agreements cover a very wide scope and are to be developed in consultation with the Indian community, and published in the Federal Register all within the short span of 90 days from enactment in H.R. 1156, and 210 days in H.R. 2624. H.R. 1156 also requires the agreement to be submitted to Congress within 90 days of enactment. The agreement is to include permission for local IHS and BIA officials to enter into agreements with tribes to coordinate alcohol and drug abuse services and resources. This authority already exists for tribes under the Indian Self-Determination Act, use of which would have the additional benefit of providing the tribe with those funds that IHS has been spending on the effort. Coordination and identification of available resources are two efforts we believe are most beneficially and economically performed at the local level.

However, we have no objection to entering into a general agreement with the Secretary of the Interior. We agree with the thrust of section 101(a)(3) of H.R. 1156 that BIA and the IHS should better define which agency is responsible for what services in order that the client not be bounced from agency to agency, but we do not believe legislation is required. We believe this can best be accomplished at the local level taking into account both the nature and severity of the problem and the total resource available from all sources.

We defer to the BIA on Title II of H.R. 1156 - Education.

Title III of H.R. 1156 and Sec. 4 of H.R. 2624 - mandates certain family and social services training activities including, in the case of H.R. 1156, a minimum of two weeks training for new Community Health Representatives (CHR) and health aids on the problems of alcohol and drug abuse. H.R. 2624 requires CHR training but no specific time frame is mandated. The President's budget for fiscal year 1986 does not provide for continued funding of the CHR programs. In addition, section 301(b) of H.R. 1156 requires the Director of the IHS (H.R. 2624 requires the Secretary of HHS, in consultation with the Secretaries of the Interior and Education) to provide certain training, upon request, to a long list of eligibles.

We defer to the BIA on Title IV of H.R.-1156 - Law Enforcement.

Programmatically, section 502 sets up a program that relies only on IHS and P.L. 93-638 contractor facilities. This is at variance with the current practice of identifying and relying on all available resources.

Section 502 of H.R. 1156 is based on the premise of the Secretary of Health and Human Services having the sole responsibility for residential alcohol and drug abuse treatment centers for Indian juveniles. We believe this could go beyond the health related authority and responsibilities that were transferred to the Public Health Service in 1954 and could remove or cloud those responsibilities remaining to the Secretary of the Interior.

We are in harmony with the Congress' effort to affect the alcohol and drug abuse problem in the Indian community but the Department opposes enactment of H.R. 1156 or H.R. 2624.

That concludes my statement. I will be happy to answer any questions you may have.

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TESTIMONY ON HR 1156 AND HR 2624: THE INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT

Mr. Chairmen and Members of the Committee:

On behalf of the 37 federally recognized tribes of Oregon, Washington, and Idaho, I would like to thank you for the opportunity to testify on HR 1156 and HR 2624: The Indian Juvenile Alcohol and Drug Abuse Prevention Act. Our Northwest tribes have followed the development of this legislation with great interest and strongly support the initiative taken by Representatives Bereuter and Daschle in deciding to attack one of the most serious health problems in Indian country--that of alcohol and substance abuse among our youth.

The Northwest Portland Area Indian Health Board has repeatedly taken strong positions against substance abuse. At our last Quarterly Board Meeting on October 17, 1985, we took the stand that alcoholism is a life-threatening disease and its treatment should be accorded high priority by the Indian Health Service, a funding priority not now received.

We have also been extremely concerned over the years about the low level of resources currently available to our tribal alcohol programs. Because most of our small tribes did not have the grant-writing capability to receive NIAAA grants in the days when the grants were available, many of our tribes are not now able to receive alcohol program funds through the Indian Health Service as with a few small exceptionsIHS only funds prior NIAAA grantees. This has caused extreme hardship throughout our area, leaving many communities with few or no resources to address the substance abuse epidemic.

We applaud the emphasis on prevention on HR 1156 and HR 2624. Because of the overwhelming caseloads of adult substance abuse, Indian alcohol programs have historically paid little attention to prevention. These bills direct a much-needed spotlight on this critically-important area and make a strong beginning in the development of expertise and resources for prevention programs.

The NPAIHB is in full agreement with the testimony on these bills provided by the National Congress of American Indians and the National Indian Health Board. However, we are most disappointed by the Indian Health Service and the Bureau of Indian Affairs when they testified on S. 1298. We will address their comments on the bills' provisions as we discuss each Title of the Act.

Title I - Inter-Departmental Agreement

The NPAIHB supports the concept of inter-departmental agreements between the Bureau of Indian Affairs and the Indian Health Service to coordinate programs and delineate responsibilities for alcohol and drug abuse programs. However, it is essential that these activities at both the national and local levels be carried out in full consultation with the tribal governments. We disagree with the statement made by the Indian Health Service that these agreements are not needed at the national level but are handled locally. National leadership is needed to provide direction and consistency. In our area, no working agreements between IHS service units and BIA agencies exist.

We are not in favor of the proposal in the HR 2624 to establish an Office of Juvenile Alcohol and Drug Abuse within the Alcohol, Drug Abuse, and Mental Health Administration. This should be located within the Indian Health Service for better coordination with tribal programs and should be made statutory.

We are also unsure of the wisdom of re-allocating existing program funds to designated crisis areas as specified in HR 2624. The withholding of anticipated funds from tribal contracts severely damages program continuity in our tribal substance abuse programs, which are already severely underfunded. It would be more appropriate to establish a newly-appropriated "crisis fund" to be administered by IHS headquarters to deal with emergency situations.

Title II - Education

The NPAIHB believes that training of school counselors in BIA and tribal and public schools is essential and endorses the amendment of the Indian Elementary and Secondary School Assistance Act for this purpose. We also agree with the establishment of a priority for training in this area through the Indian Education Act as provided in HR 1156, Section 202. The lack of qualified personnel in tribal alcohol programs has long been a serious problem for our Northwest tribes. At the present, only 45 percent of Northwest tribal alcohol personnel meet certification requirements. A mandated program of instruction for all BIA and BIA-funded schools is also most appropriate, although we must agree with our national Indian organizations that such curricula must be locally designed or modified in order to be culturally relevant.

Alcohol and drug education must be designed keeping the Indian culture in focus. Traditionally, those alcohol programs that incorporate American Indian cultural related activities have demonstrated the most success.

The NPAIHB fully supports Section 205 of HR 1156, which requires the establishment of summer recreation and counseling programs for Indian youth on reservations. These programs, which should be designed by qualified recreation therapists and staffed by salaried coordinators, should be required for all students as a means for developing self-esteem and healthy alternatives to substance abuse. By pinpointing students who need follow-up attention, prevention and treatment can be integrated.

The Model Recreation Therapy Program at the Chemawa Indian School in Salem, Oregon provides an excellent example of the value of this approach. Students at the school have benefitted by building social skills, teamwork, self-confidence, and leadership qualities--all of which are important prevention goals. However, this is the only program of this type anywhere in Indian country.

The national BIA-sponsored newsletter on Indian alcohol and drug abuse as required in Section 206 of HR 1156 would be an excellent means of providing information and coordination of alcohol and drug abuse-related material and resources to Indian people. We would have a problem of sandwiching the topic of alcohol and drug abuse with an Indian Child Welfare linkages newsletter, as the BIA suggests, as each topic warrants special attention to its respective subject matter.

Title III - Family and Social Services

The NPAIHB strongly supports training for community health representatives in alcohol and drug abuse; these personnel urgently need a comprehensive training program in this area, but funds for CHR training have been minimal in recent years.

Training in alcohol and drug abuse for BIA, IHS, and tribal leaders, employees and community members, is also an urgent need. Personnel of public schools in every state which are on or near Indian reservations with significant numbers of Indian students should also be included, as noted in HR 2624. However, to accomplish this extensive training a substantial appropriation of funds will be required.

Title IV - Law Enforcement

The training of BIA, tribal, and federal law enforcement personnel is essential in any effort to prevent or combat juvenile substance abuse as the lack of consistent enforcement of substance abuse laws is one of the biggest problems in this field.

A major problem facing the tribal police is not having a facility (i.e. not having a crisis center, emergency shelter or detention area) in which to place the Indian youth identified as being intoxicated. When the youth are picked up, usually in early morning hours, the tribal police may drive a youth around looking for his parents or relatives. The only alternative that is available is a county jail. This is not an acceptable solution to the problem. Many times a youth will get lost in the state system and may cost the state and tribe more than it would cost to retain him on the reservation.

The requirement that BIA establish a program for Indian households to be compensated to serve as temporary emergency shelters for substance-abusing youth is an excellent idea and would serve well in areas without regular emergency shelters if the tribal members are trained to deal with the cases. The comment made by the BIA that no new special funding authority is needed to establish these temporary shelters is misleading, as the network of reimbursed foster homes supported by the Indian Child Welfare grants is not large enough to impact this problem, nor are the family members trained to deal with these often violent young people.

In 402(c)(2) of HR 1156, the tribal council should not only approve the shelters but establish the licensing requirements.

Funding for more emergency shelters for youth in these situations is urgently needed. Only one tribe in the Northwest has such a shelter. Other tribes must house these youth in tribal jails or take them to non-Indian facilities elsewhere.

Title V - Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation

As the Northwest has no Indian Health Service hospitals, the establishment of comprehensive treatment services in IHS and '638' inpatient facilities, as directed in HR 1156, would not meet the needs of our juvenile population. Two youth treatment centers separate from hospitals are needed in the Northwest. Services to communities lacking IHS hospitals are addressed in Section 503 of the bill, which we fully support.

The study of the extent of need and cost of treatment for juvenile substance abuse is essential. Six months may not be enough time to complete it in a comprehensive manner. A substantial appropriation for the establishment of juvenile treatment facilities would be an important outcome of this study.

Title VI - Definitions, Effective Date, and Authorization of Appropriations

In this section it should be made clear that the term "drug abuse" includes the abuse of inhalents. Inhalent abuse is a growing area of concern among our Northwest tribes and requires special education and intervention techniques.

Essential to the accomplishment of the provisions in HR 1156 is that the appropriations be adequate to permit accomplishment of the various objectives. We are not sure that $5 million is adequate to this task. "Such sums as may be necessary" might be more appropriate language.

The requirement in HR 2624 that tribes or tribal organizations provide 25 percent of the cost of the program would not be realistic for most of our Northwest tribes. Areas where the need is most urgent would not be able to participate at all. We oppose this matching funds requirement.

With the changes noted in our testimony, the NPAIHB believes that HR 1156 is an outstanding bill which will provide the needed programs and coordination to combat the problem of juvenile substance abuse. We commend the House Interior Committee for its work on this bill and urge that HR 1156 be enacted into law with all possible speed.

NATIONAL TRIBAL CHAIRMEN'S ASSOCIATION

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October 24, 1985

TESTIMONY OF THE NATIONAL TRIBAL CHAIRMEN'S ASSOCIATION BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS ON HR 1156, A BILL TO COORDINATE AND EXPAND SERVICES FOR THE PREVENTION, IDENTIFICATION AND TREATMENT AND FOLLOW-UP CARE OF ALCOHOL AND DRUG ABUSE AMONG INDIAN YOUTH, AND FOR OTHER PURPOSES.

Good morning, Mr. Chairman. My name is Raymond C. Field, the Executive Director of the National Tribal Chairmen's Association. Today I am speaking on behalf of the National Tribal Chairmen's Association's membership which is composed of 183 federally recognized Indian Tribes.

Our Indian people are deeply concerned about juvenile alcohol and drug abuse and the continued growing potential to harm and in many cases, the destruction of our Indian youth. The problem has virtually failed to be addressed in a sufficient manner.

Our concern increased when we heard about the nine (9) tragic suicides on the Wind River Reservation in Wyoming. The potential for further destruction is quite alarming as we realize suicide and substance abuse can be close comrades. To reduce this destructive potential, the National Tribal Chairmen's Association urges the Congress to integrate the following comments and suggestions to enhance the preventive and service aspects of the proposed bill.

In Section 101, expansion is needed to specify actual coordination guidelines and follow-up procedures for coordination of BIA and IHS programs. For example. One of the functions of this section may be to refine information sharing of the more sophisticated programs, so that other programs may benefit and grow to better serve students.

In identifying Federal, State, Local and private resources, an information resource document specific to each area can be compiled and published indicating; (a) type and description of service available, (b) procedures on how to obtain the service, and (c) contact people with phone numbers who can assist agencies, areas and contract schools. The document can include helpful information about alcohol and drug abuse for those pursuing assistance. To effectively coordinate alcohol and drug abuse related services, the BIA/IHS personnel must be qualified to provide meaningful technical assistance to existing programs and have the ability to develop program components where none exist.

To determine the scope of the Indian Alcohol and Drug problem and its estimated financial and human cost, a survey tool can be developed by qualified and experienced employees. There should be input from alcohol and drug treatment centers, support groups, students, counselors and noted authorities in the field.

In the case of responding to tribal requests in Section 102, the BIA and IHS should develop a set of guidelines to coordinate comprehensive resources and services. An additional format is needed to address alternative program planning in situations where no services exist.

In the Title II Education part discussing the Indian Education Act, we recommend a educational title which includes a provision for a new fellowship category be added for Indian persons who undertake a health career education which related to alcohol and drug abuse, e.g., clinical psychology. Within s 201, the National Tribal Chairmen's Association urges a provision for alternative youth activities. Besides specifically designed agency and tribal program, we seek the provision of constructive, productive and healthful activities for our Indian youth. For example, Bureau and tribal educators could be employed as resource people for youth activities, e.g., camping, tribal language, singing and dancing.

Under Title II, Education S. 204 a specific criteria of components must be listed as part of the alcohol and drug prevention program of instruction for BIA and contract schools. Those components must include:

(1) Comprehensive curriculum indicative of current substantiated research, i.e. medical facts, physiological processes of addiction, cross-addiction, mental and emotional aspects, self-identification, treatment and support system networking.

(2) Suicide prevention information and a prevention plan addressing the high correlation between substance abuse and suicide incidents.

(3) Qualified and trained personnel who have expertise in prevention, identification, intervention and program implementation and who have the ability to effectively listen to and interpret what students say.

(4) Involvement of support groups of Alcoholics Anonymous and Narcotics Anonymous.

(5) Peer counseling participation of former substance abusers. These student counselors will not act as informants, but will serve as peer role models trained in identification who can assist other students to break through their own denial system.

(6) A parent involvement plan will be established within the program to assist parents in how to recognize the problem and what they can do about it. Teachers and other school personnel should also be included.

(7) Provision for adequate training for persons responsible for program service delivery, similar to the Family and Social Service content section.

The Family and Social Services Section, 301 (a) states, any training program for community health representatives shall include not less than two (2) weeks of training on the problem of alcohol and drug abuse along with related areas. Two weeks training for community health representatives is not sufficient. The Training base on problems of substance abuse must be no less than a 28 day treatment program. This will provide a beginning format of information with experiential counseling techniques. After the base training has been completed, a minimum of 3 to 5 two day workshops should be provided to each individual on crisis intervention, family dynamics of therapy, alcohol and drug support groups, fetal alcohol syndrome and suicide prevention. These workshops and general substance abuse information should be made available to all designated persons in section 301 (b), including dessemination of such information throughout Indian country.

The law enforcement officials referred to in Title IV, Section 401 must receive training by the BIA, which includes education on the problems of alcohol and drug abuse among Indian juveniles. The implementation of this BIA training should have similar components stated in the previous paragraph on Family and Social Services Section 301. At a minimum, law enforcement officials must participate in 3 to 5 two day workshops on substance abuse education and medical research, crisis intervention, conflict management and counseling techniques in drug abuse situations, suicide prevention and referral-resource information.

The study in Title V, Section 501 to be completed by IHS within 6 months of the date of enactment of this Act, and to determine the state of juvenile Indian substance abuse in need of treatment, should be done jointly with qualified representation from the BIA. It is imperative a well defined survey tool be developed which is designed to extract correct information of the existing problems. If the individuals developing and implementing the study are not knowledgable and skilled in this specialized area, the true picture of the problem will not be obtained.

On behalf of the National Tribal Chairmen's Association, I thank you for the opportunity to testify on this important piece of legislation.

STATEMENT OF SUZAN SHOWN HARJO, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS, ON H.R. 1156, INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT, BEFORE THE HOUSE OF REPRESENTATIVES INTERIOR AND INSULAR AFFAIRS COMMITTEE, OCTOBER 24, 1985.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to testify on behalf of the National Congress of American Indians (NCAI) and the National Indian Health Board (NIHB) on H.R. 1156, the Indian Juvenile Alcohol and Drug Abuse Prevention Act. We are heartened that the Senate Select Committee on Indian Affairs is also considering this legislation, and view the bill as a potentially important part of efforts throughout Indian country to halt the epidemic of alcohol and drug abuse. The prevention ar treatment of alcohol and drug abuse is a primary interest of both NCAI and NIHB. Attached to this statement is the position paper on Alcoholism and Drug Abuse adopted at NCAI's 1984 Convention which I would like included in the official hearing record. As you will see, the paper advocated enactment into law of what was then H.R. 6196, the Indian Juvenile Alcohol and Drug Abuse Prevention Act introduced by Representatives Bereuter and Daschle in 1984. In addition, the NCAI conference in Tulsa October 7-11, 1985 reaffirmed its support for Congressiona fforts in the area of prevention of Indian substance abuse.

We strongly support H.R. 1156. While increased federal involvement in the prevention of substance abuse is long overdue, this legislation is part of the increased national awareness and resolve to stop alcohol and drug abuse and its attendant destruction. We are pleased to see that in both the House and Senate this legislation has bipartisan cosponsorship, representing a wide ideological and geographical spectrum. Because of the bipartisan nature of the bill and the high level of national commitment to halt substance abuse, we feel the climate is right to enact H.R. 1156 into law.

We urge this Committee to utilize this opportunity to strengthen the legislation, enact it into law, and to work for a more reasonable allocation of funds for the prevention and treatment of alcohol and drug abuse. NCAI and NIHB have and will continue to advocate higher appropriations for Indian alcohol and drug abuse programs. While the Interior Committee is an authorizing committee, we hope that your consideration of H.R. 1156 will in part result in a strong stance for increased appropriations for substance abuse programs. Despite the fact that four of the leading causes of death among Indian people - cirrhosis of the liver, accidents, suicides and homocides - are directly related to alcohol and drug abuse, less than one half of one percent of the Indian Health Service budget is allocated for alcohol and drug abuse programs. And, while the Indian Health Service (IHS) appears to be increasing its focus on prevention of abuse in this area, the fact remains that even the little money it does have - $26 million in FY'85 - is for treatment of adult alcoholics in the advanced stages of alcoholism. We do not favor shifting money from treatment to prevention, as treatment is desparately needed. We do want more financial and administrative resources committed to prevention of alcohol and drug abuse.

The Research Triangle Institute estimates that the costs of alcohol problems in the United States in 1983 was $116 billion. Nationally, the cost of treating a chemically-dependent person on an inpatient basis ranges between $12,000 and $20,000. The success rate is only about 30%. The United States has been penny-wise and pound-foolish in its approach and alcohol and drug abuse. The same holds true for the Bureau of Indian Affairs (BIA) and the IHS, which historically have denied responsibility and done little to coordinate existing substance abuse efforts and programs. The IHS and BIA are, in some cases, working cooperatively with each other and with Indian governments. But, in the absence of legislation, we do not feel that the BIA and IHS will exhibit the necessary resolve to coordinate and share resources, to fund programs that tribes want and to increase the level of knowledge and sensitivity within their agencies that is necessary for an all-out effort to prevent alcohol and drug abuse.

The Administration's testimony October 18th in opposition to the Senate companion legislation is evidence of why the bill is needed. The Administration's testimony that schools have susbstance abuse programs and that there is cooperation between IHS and BIA at the local level is not consistent with the comments from Indian country. We are perplexed by the BIA testimony before the Senate Select Committee on Indian Affairs that Tribal/BIA agreements regarding coordination of resources and services related to alcohol and drug abuse would "force assistance to be allocated on a first-come, first-served basis rather than to where the greatest need might exist." We do not see coordination and sharing of activities regarding substance abuse to be anything other than beneficial.

We were also taken aback by the Bureau's statement that they do not want any authority for emergency shelters or facilities for Indian youth apprehended for offenses related to substance abuse, because it might duplicate existing facilities supported by the Indian Child Welfare Act. As the Bureau knows, or should know, the Indian Child Welfare Act grant program has never awarded a grant for juvenile care facilities. Furthermore, the Indian Child Welfare

Act is designed for abused, neglected and orphaned children. Youth arrested for offenses which would be a crime if they were adults do not fall under the purview of the Indian Child Welfare Act.

The Indian Health Service testimony in opposition to the Senate companion legislation made the weak argument that the bill is not needed because there "are school-based programs also operating in several parts of the country" and that there are working agreements with regard to alcohol and drug abuse efforts "in many locations." If these programs and agreements are, in fact, operating in some areas we do not understand why IHS would oppose legislation requiring school-based programs in all parts of the country and IHS/BIA working agreements with all tribes.

We would note that there was considerable constructive dialogue with BIA and IHS officials during the drafting of the Juvenile Indian Alcohol and Drug Abuse Prevention Act, and so we wonder how the Administration arrived at its decision to oppose this legislation.

An important value of H.R. 1156 and the Senate companion legislation is that it can be a stimulus for increased local efforts. The required cooperative agreements, sharing and coordination of resources, the locally-developed education curricula and, very importantly, the training and education offered to a wide variety of Indian people should lead to a better utilization of available resources and activate a much larger portion of the Indian community into battle against alcohol and drug abuse.

In talking with people about this legislation and in reading testimony presented at the four previous hearings held by the House Interior Committee and the Senate Select Committee on Indian Affairs, four points are made over and over again:

1) School curricula designed to prevent alcohol and drug abuse must be locally designed or modified in order to be culturally relevant. The bill makes no specific mention that curricula should be culturally relevant. However, our reading of the bill is that it requires BIA and Contract schools to offer curricula in grades K through 12, but that the actual design and choosing of the curricula would be local. Tribes and school districts, of their own volition, would likely design or choose curricula which they feel would fit the cultural needs of their students. Nevertheless, due to the large number of comments about this, we suggest that the bill or report language clarify that curricula is to be locally chosen.

2) All programs, studies and training authorized under this bill should be contract-eligible activities. The training and the renovation of facilities portions of the bill do specify these as contract-eligible activities. We would suggest that language be added to Section 501 of the bill which would make it clear that the study of the need for juvenile residential alcohol and drug abuse treatment could be contracted by tribes or tribal organizations.

3) More appropriations are needed for juvenile treatment facilities, for counsellors and for locally-based facilities that can serve as an alternative to incarceration. We prefer the Senate language authorizing such sums as may be necessary for the legislation, as compared to the H.R. 1156 language authorizing $5 million for training and a

study and a possible further authorization for renovation and construction of facilities.

4) Indian students in public schools need to be included in any legislation dealing with prevention of alcohol and drug abuse among Indian youth. We support sections 201, 202 and 203 of H.R. 1156 which utilizes the Indian Education Act as a means to reach Indian public school students. Well over half of the Indian youth attend public schools, and we agree with the view that they must receive culturally relevant education and counselling regarding substance abuse. In Montana, Nebraska and Alaska, for instance, nearly all Indian students attend public schools. H.R. 1156 specifically includes alcohol and drug abuse counselling in schools as an eligible activity unde Part A of the Indian Education Act; earmarks 10% of fellowships in Part B of the Indian Education Act for degrees in counselling; and includes substance abuse counselling as an eligible activity under Part C of the Indian Education Act. Part C of the Act provides funds for urban Indian centers. The Senate bill does not contain any provisions regarding the Indian Education Act as a means to reach public school and urban Indian students, and if it is not modified to address the needs of these students, we would urge the conferees to adopt sections 201, 202 and 203 of the House bill.

The National Congress of American Indians and the National Indian Health Board would also support amendments to the bill which would address the needs of pre-school age children. It is well established that early intervention is effective in developing skills and attutides which will increase children's chances for futures free of alcohol and drug abuse. It is very unfortunate that there are no longer any BIA pre-schools as Head Start serves only 18% of the eligible pre-school age population. The Johnson O'Malley program is able to provide a small amount of services to pre-school age children, but cannot possibly meet the need. We suggest that Section 301(b)(2) of H.R. 1156 be amended by including Head Start and other pre-Kindergarten child care givers the opportunity to receive alcohol and drug abuse training. Additionally, section 706(c) of H.R. 1426, the Indian Health Care Improvement Act Amendments, could be amended to require the dissemination of curricula and other materials relevant to pre-Kindergarten age children available to pre-schools which serve Indian children. The provision in H.R. 1426 currently relates to the collection and dissemination of alcohol and drug abuse curricula and materials for students in grades K-12.

Whatever one's age, alcohol and drug abuse prevention and treatment cannot generally be dealt with successfully outside of a family and community context. We support the provision in Section 204 which encourages family participation in educational instruction and the provision in Title III which includes family relations in alcohol and drug abuse training.

Counsellors must also operate in a family context. However, lack of trained chemical dependency counsellors and a high turnover rate among counsellors present major problems. Often there are no counsellors, or only one counsellor, for hundreds of students and their families. In many cases counsellors do not have adequate training. John Williams, a member of the Oglala Sioux Tribe and Director of the University of South Dakota's Alcohol and Drug Abuse Counselling Division, pointed out in his testimony on H.R. 1156 that there is no uniform alcohol and drug abuse training program adopted nationwide. There is no training model that standardizes information, has career ladder capabilities, increases counsellor competency levels and teaches research skills. We do not accept this training for our doctors and nurses and teachers, and we should not accept it in counsellors. It may be outside the purview of this legislation to address the subject of chemical dependency counsellor training models. However, a 10% set-aside of Part C Indian Education Act monies would ensure about 10 or 11 Indian students being trained each year as counsellors. Perhaps a better or additional approach would be to authorize an endowment or scholarship fund for Indian students in the field of chemical dependency counselling.

We support the provision in H.R. 1156 which would require that some BIA and/or contract schools remain open in the summer to provide recreational and educational activities and counselling services. Lack of summer activities is a serious problem for reservation youth. While it would require some additional money to keep selected schools open, it would be well worth the investment. The Senate bill does not contain this provision, and we hope that the final version of this legislation incorporates the House language regarding summer activities.

We applaud the emphasis this bill places on alternatives for juvenile incarceration for alcohol and drug related charges. This is one of the most difficult areas in which to legislate. Incarceration of juveniles, sometimes in adult jails without proper isolation from adults, is a national problem. Tribes generally have even fewer resources to deal with this problem than do states. Last year 300,000 youth in the United States were incarcerated, with only 10% of them being arrested for serious crimes. H.R. 1156 requires the BIA to develop guidelines for incarceration of Indian juveniles when an emergency shelter or treatment facility is not appropriate. This would likely occur in cases where the youth is violent. The House bill contains the safeguard that no BIA guidelines or regulations may supercede tribal laws. The Senate bill does not contain this provision. We feel that any final legislative product must contain the House language protecting tribal self-government in this area.

Both the House and Senate bills provide for the BIA to establish licensing standards for homes to serve as emergency shelters in lieu of incarceration and they also require tribal council approval for emergency shelters. We feel that the licensing process should be left entirely up to the tribes. In addition, circumstances differ too much from tribe to tribe to make uniform licensing standards workable.

The study in Section 503 to identify facilities that can be utilized as juvenile alcohol and drug abuse treatment centers should focus on options that would allow Indian youth to remain near their homes for treatment. The bill language does not preclude this focus, but language to ensure that local options are considered would be helpful.

We suggest that section 502(a) which requires IHS to provide comprehensive alcohol and drug abuse services be amended to include consultation with tribes,because what is considered comprehensive substance abuse services will vary from tribe to tribe. It is possible that this type of tribal-specific planning would come about as a result of the memorandum of agreements between tribes, the IHS and the BIA provided for in Title I of the bill.

We have, in addition, two suggested technical changes in the bill: 1) in the title substitute the word "youth" for "juvenile", as the latter carries the popular connotation of delinquency and 2) in the title add the word "inhalant" so the title would read "Indian Youth Alcohol, Drug and Inhalant Abuse Prevention Act". Alternatively, report language could make it clear that inhalant abuse is covered under the bill. Inhalants are drugs, and our understanding of the legislation is that they are included in its provisions. However, due to the increasing use of gasoline, correcting fluid, lysol and other inhalants, especially among grade school children, we feel it is important to emphasize their inclusion in the legislation.

Thank you very much for the opportunity to comment on the Indian Juvenile Alcohol and Drug Abuse Prevention Act. We are very encouraged by the bill's introduction and the priority assigned it by the House Interior Committee and the Senate Select Committee on Indian Affairs. The National Congress of American Indians and the National Indian Health Board look forward to continued communication with the Members and staff of the House Interior Committee as we move closer to a markup of this legislation.

NATIONAL CONGRESS OF AMERICAN INDIANS
41ST ANNUAL CONVENTION
POSITION PAPER
ON
ALCOHOLISM AND DRUG ABUSE

Spokane, Washington
September 13, 1984

PROBLEM

A. The Indian Health Service Office of Alcohol Programs was established in March, 1978. In P.L. 94-437 Congress identified the purpose of this office as the treatment and control of alcoholism amongst American Indians. To carry out this purpose the Office of Alcohol Program adopted nine major objectives recognizing that some of these objectives had not been achieved and that only limited progress had been made on others. Dr. Rhoades, Director of Indian Health Service and Dr. Graham, Director of Health Resources and Services Administration agreed that a study should be made of Indian Health Service Alcoholism Programs. This study was carried out during the period of October, 1983 to June, 1984, by an independent research and development company under contract with the Health Resources and Services Administration. The primary purpose of this study was to identify and assess Indian Health Service model alcoholism programs. The secondary purpose was to develop a set of recommendations for alcoholism programs funded by Indian Health Service. The study identified and surveyed 19 highly successful Indian aloholism programs. The title of the study report is Identification and Assessment of Model Indian Health Service Alcoholism Projects.

Each organization surveyed reported a large number of problems and unmet needs. These include inadequate or inappropriate policies, the lack of a well-defined service population, inadequate or obsolete program facilities, lack of adequately trained staff, inadequate number of staff, limited or inadequate funding and inadequate assistance and guidance from the Indian Health Service at the Area and Central Office levels.

The study report also includes a detailed description of six program models (prevention/outreach, detoxification, primary residential treatment, halfway house, outpatient, and custodial care).

CONCLUSION

A. This study identified and assessed a small number of successful programs. Because it may be assumed that the less successful programs would have more serious problems and a greater number of unmet needs we may reasonably conclude that the majority of Indian Health Service funded programs are not providing an adequate level of services to the clients and communities they serve. The magnitude and nature of these problems indicates a definite need for new congressional legislation mandating the development of adequate and effective alcoholism services for Indian people.

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RECOMMENDATIONS

A. Identification and assessment of model Indian Health Service Alcoholism Projects (Contract No. 240-083-0100 for the Health Resources and Services Administration, Department of Health and Human Services) with modifications from the NCAI Alcoholism and Drug Abuse Committee. Based on study findings presented in this report it is hereby recommended that:

Recommendation 1

THAT THE NCAI SEEK A COMMITTMENT FROM THE PRESIDENT OF THE UNITED STATES AND HIS ADMINISTRATION TO REQUEST A MINIMUM INCREASE OF $10 MILLION DOLLARS IN CONGRESSIONAL APPROPRIATIONS FOR IHS COMMUNITY AND URBAN ALCOHOL PROGRAMS FOR FISCAL YEAR 1986. IT IS ALSO REQUESTED THAT THE PRESIDENT PROVIDE FOR THE DEVELOPMENT OF A LONG RANGE (TEN TO FIFTEEN YEARS) PLAN WHICH WOULD INVOLVE A COORDINATED EFFORT OF THE EXECUTIVE BRANCH AND THE OFFICE OF MANAGEMENT AND BUDGET DURING APPROPRIATION HEARINGS. THE NCAI IS DIRECTED TO REQUEST FROM THE U.S. CONGRESS, TO DEMONSTRATE ITS COMMITTMENT TO THE UPGRADING OF THE HEALTH OF THE INDIAN PEOPLE AND ALLEVIATING THE ADVERSE EFFECTS OF ALCOHOL AND DRUG ABUSE, PASSAGE OF A CONGRESSIONAL BILL THAT WOULD PROVIDE THE NEEDED AUTHORITIES AND FUNDS TO ELEVATE THE LONG RANGE GOALS OF THE INDIAN ALCOHOLISM AND DRUG PROGRAMS.

Administrators and staff members of the study programs identified the need for additional IHS funds as the most critical need for strengthening their programs. Increased IHS funds are needed for 1) employing additional program staff, 2) increasing current staff salaries, 3) providing additional funds for training and education of counselors and administrators, 4) establishing alcohol programs in communities which have a critical need for additional services, 5) recognizing and compensating those programs which on the basis of standardized evaluation criteria demonstrate their compliance with appropriate standards for effectiveness and efficiency, and 6) upgrading program facilities by remodeling existing structures of constructing new ones.

The passage of a Indian Alcoholism Improvement Act would provide for and direct the Indian Health Service to carry out the following study findings as suggested in Recommendations 2 through 9:

Recommendation 2

THE IHS DEVELOP A THREE-YEAR PLAN FOR TESTING AND IMPLEMENTING THE SIX ALCOHOL PROGRAM MODELS (PREVENTION/OUTREACH, DETOXIFICATION, PRIMARY RESIDENTIAL TREATMENT, HALFWAY HOUSE, OUTPATIENT, AND CUSTODIAL CARE) DESCRIBED IN THIS REPORT.

The plan to be developed under this recommendation should include but not be limited to the following provisions:

1) Appointment of an _ad hoc_ technical review groups, composed of persons who have extensive pragmatic and theoretical knowledge of alcohol program development and evaluation, to serve as a planning advisory group on the development of the three year plan;

2) Development and implementation of a pilot study to field test the models with a selected sample of IHS community alcohol programs;

3) Development of an implementation plan for converting IHS alcohol programs to a new system based on the program models in accordance with the findings of the pilot study;

4) Provision of relevant training for the IHS Area Alcohol Coordinators on the important elements of the new system;

5) At the end of the three-year period, development of a status report by the technical review group for submission to the IHS Director documenting the feasibility of using the new system for IHS community alcohol programs.

Recommendation 3

THAT THE INDIAN HEALTH SERVICE SOLICIT INPUT FROM THE IHS ALCOHOLISM PROGRAMS TO DEVELOP A NEW CLIENT MANAGEMENT INFORMATION SYSTEM WHICH ESTABLISHES a) FINANCIAL ACCOUNTABILITY; b) CONTRACT COMPLIANCE; c) PATIENT OUTCOME; AND d) QUALITY OF SERVICES. THIS SYSTEM SHOULD BE LIMITED TO EITHER ONE OR TWO PAGES TO AVOID LOSS OF COUNSELOR TIME AND BURDENSOME PAPERWORK WHICH AFFECTS QUALITY DELIVERY OF SERVICE. ASSESSMENT, DISCHARGE AND FOLLOW-UP MEASUREMENT OF SERVICES WOULD NEED TO BE INCLUDED IN THIS COMPILATION OF CLIENT DATA.

Survey findings indicate that alcohol treatment programs have problems related to client assessment at three different states in the service delivery process. These are assessment of the client's level of functioning at intake, discharge and post-treatment follow-up.

Two programs in this study reported successful discharge rates of 30 and 38 percent, and two other programs reported successful discharge rates of 100 percent for fiscal year 1983. The comprehensive programs did not report any discharge rates by specific program components, possibly because of their practice of transferring clients from one program to another without discharging them. Excessively low or high discharge rates may indicate that clients are not properly diagnosed nor placed in appropriate program components at the time of intake. Inappropriate diagnosis and placement of clients has important implications for treatment outcome and may directly affect the rate of successful discharges.

During fiscal year 1983, only eight percent of 166 IHS alcohol programs reported client follow-up measures and, in this study only two of the 12 programs reported client follow-up data. These low rates of client follow-up indicate a need for the development of new client follow-up policies and procedures.

The IHS needs to implement a reliable and objective system for determing the client outcome effectiveness of IHS-funded programs. The implementation of this recommendation will provide a foundation for the development of such a system.

Recommendation 4

THAT IHS DEVELOP AN EDUCATION AND TRAINING PROGRAM TO MEET THE CAREER DEVELOPMENT NEEDS OF COUNSELORS AND ADMINSTRATORS. THE PROGRAM SHOULD INCLUDE COMPETENCY BASED CURRICULA AND PROVIDE APPROPRIATE ACADEMIC CREDIT FOR STUDENTS COMPLETING COURSE REQUIREMENTS.

Information from the study shows that 20 of 58 counselors are certified alcohol counselors. In four of the 12 programs none of the 19 counselors are certified. Of the 58 counselors, five did not complete high school, 28 have high school diplomas, six have associates of arts degrees, eight have baccalaureate or master's degrees, and 10 additional counselors have completed some college courses. This information was not available for the one remaining counselor.

During the site visits, program administrators expressed an interest and need for further education and training in the areas of program management and supervision, resource development, program evaluation, and other administrative topics.

Members of the expert panel recommended that the IHS give consideration to two strategies for implementing this recommendation: 1) Explore the feasibility of utilizing the IHS Continuing Education Program which is used to train medical and clinical personnel, and 2) negotiate with administrators of local community colleges and Indian-controlled colleges for the inclusion of appropriate alcohol studies courses in their curricula.

Recommendation 5

THE IHS PREPARE ANNUAL IHS ALCOHOL PROGRAM CONTRACTS WHICH SPECIFY BUDGET ITEMS, STAFFING REQUIREMENTS, SCOPE OF WORK, AND OTHER MAJOR CONTRACT CONDITIONS FOR EACH SPECIFIC PROGRAM COMPONENT.

The two comprehensive programs included in this study were not able to report budget information and program data separately for each of their IHS-funded components. The information they reported was based on estimates, rather than actual data.

The intent of this recommendation is to produce accurate and valid program information needed by the IHS Area Alcohol Coordinators to monitor contract compliance and determine program accountability measures.

Recommendation 6

THE IHS DEVELOP A POLICY THAT DEFINES THE CONDITIONS UNDER WHICH RECIPIENTS OF SERVICES FROM COMMUNITY ALCOHOL PROGRAMS ARE CLASSIFIED AS PROGRAM CLIENT, REGISTRANT OR ENROLLEE ACCORDING TO THE TYPE OR PROGRAM PROVIDING THE SERVICE.

Study findings indicate that programs use different methods for determind client counts. For some programs the client counts appear to be inflated due to the practice of counting members of autonomous community support groups who are not receiving direct services from the programs. Also, the comprehensive program may be under-counting clients due to the practice of transferring them from one program compoenent to another without discharge.

The intent of this recommendation is to provide the IHS and community alcohol programs with a more precise method for determining client counts. The use of a uniform approach to determining the conditions under which a person may be counted as a client, registrant or enrollee should eliminate apparent inequities in the system.

Recommendation 7

THE IHS DEVELOP A PROGRAM OPERATIONS IMPROVEMENT PLAN FOR EACH IHS AREA TO IDENTIFY ACTIONS NEEDED TO IMPROVE OPERATIONS OF COMMUNITY ALCOHOL PROGRAMS.

The plan to be developed under this recommendation should include but not be limited to the following actions:

1) Appointment of an Area Alcohol Planning Committee, composed of persons who have knowledge on program planning, development and evaluation (including persons working in the fields of human services, social work, health care, law and order, education, etc.);

2) Conduct an IHS Area needs assessment to determine where alcohol programs services should be located for a more efficient service-delivery system, with special emphasis on the needs of underserved groups, such as women and youth;

3) Develop an Area alcohol training plan for IHS health care providers (including hospital and clinic staff);

4) Provide guidance and assistance to local community alcohol programs to help them identify additional financial resources;

5) Direct the Office of Environmental Health to provide training and technical assistance for the purpose of helping local programs bring their facilities into compliance with applicable codes and regulations;

6) Develop policies for the establishment of local program advisory committees to provide technical guidance and advocate for additional program resources.

Advisory committees at both the Area and local program levels are needed to provide increased community support and a braoder base of professional leadership for strengthening the IHS service delivery system and increasing the effectiveness of local programs. In the human services field advisory committees function as advocacy groups for broadening the funding base, increasing program resources, providing professional direction for improving program effectiveness, and leadership for bringing about planned change. These functions are directly relevant to the problems and needs identified in this report. The creation and use of advisory committees can provide additional leadership and support for resolving these problems and needs.

The problems and needs described in this report can be used at the Area level as guidelines for the implementation of an Area-wide needs assessment. Such an assessment can help each IHS Area determine what its priorities should be with respect to the task of strenghthening the IHS-funded community alcohol programs. Members of the expert panel suggested that much of the data required for a needs assessment may be available from the IHS computer system. Each IHS Area will need to determine what procedures will be needed to collect addictional information.

Program directors and members of the expert panel expressed interest in the feasibility and possible benefits to be derived from the use of a "continuum of care" approach to planning for strategic placement or programs in the region served by each IHS Area Office. Detoxification, primary residential treatment, halfway houses, and outpatient programs are the major components of the continuum of care process. A needs assessment will help each IHS Area determine the feasbility of this strategy for making essential services more accessible to the service population.

More training and educational programs are needed for both IHS medical and health care staff and tribal health contractors on the disease concept of alcoholism. Program directors indicated a willingness to provide alcohol training events for local IHS hospital and clinic staff but have not been utilized in this manner.

Alcohol program staff repeatedly testified to the need for obtaining more training designed to increase the level of staff knowledge and skills. Site visit consultants identified training needs primarily in administrative and treatment aspects of program operations, including for example, additional training related to the problems and needs of women and youth. In their efforts to provide additional training opportunities for staff training and education, programs have been hampered by inadequate funds and inaccessibility to education institutions.

Each program director interviewed in this study expressed need for increased funding. Program staff also reported problems and needs that were not addressed due to the shortage of funds. Study findings show that some of the programs operate on a very narrow funding base. Table 11, Page 96, shows that 71.4 percent of the total receipts reported by study programs were derived from federal government. More technical assistance is needed by local programs to help them develop additional resources and increase their level of funding from sources other than the federal government.

Study findings indicate that some programs are not licensed or certified for compliance with fire, safety, sanatation and health codes or regulations. The findings also show that most program directors reported one or more inadequacies in their facilities. The Office of Environmental Health can perform an important function for IHS-funded alcohol programs by providing technical assistance to help them improve their facilities.

Recommendation 8

THE IHS DEVELOP AND IMPLEMENT A PLAN FOR REVIEWING THE STATE-OF-THE-ARTS KNOWLEDGE ABOUT ALCOHOL-RELATED PROBLEMS AFFECTING AMERICAN INDIANS.

The plan should provide for the use of specially selected technical review groups whose members can serve as resource persons for the review of literature on new research findings and innovative treatment and prevention approaches appropriate to the goals of IHS community alcohol programs. Examples of topics to be included in the plan are: Alcohol-related morbidity and mortality, fetal alcohol syndrome, incidence and prevalence of drug use among Indian adolescents, evaluative research strategies appropriate for use at the local program level, delineation of new research needs and establishment of research priority areas.

Members of the expert panel who expressed interest in this recommendation recognize that it may be outside the focus of the present study but believe strongly that it represents an important need for the IHS and the field of Indian alcoholism.

Recommendation 9

THE IHS DIRECTOR REQUEST THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) TO CONVENE A PERMANENT STANDING COMMITTEE COMPOSED OF REPRESENTATIVES FROM THE INDIAN HEALTH SERVICE (IHS); ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA); ADMINISTRATION FOR NATIVE AMERICANS (ANA), TO IDENTIFY CURRENT ALCOHOL PROGRAM ACTIVITIES AND DEVELOP COOPERATIVE STRATEGIES FOR THE DELIVERY OF SERVICES TO AMERICAN INDIANS.

The intent of this recommendation is to provide a department-wide mechanism for sharing limited resources and strengthening cooperative program networking among the various units of the DHHS which address alcohol and drug abuse, and other health care problems of Indian people.

Members of the expert panel and the project staff believe that this committee can provide the IHS with additional programming resources for the Office of Alcohol Programs. Although this need was not identified in the study findings, the panel members believe such a departmental committee could share knowledge and develop new strategies for strengthening services for Indian people.

Presently the IHS Director has created a similar effort in establishing an Alcoholism Program Review Steering Committee which will include similar resources as cited above. This committee is planning on soliciting input from the 179 IHS Alcoholism Programs to create a creditable management tool which truly reflects program needs. The collected information will be compiled and presented for inclusion int a summary which will be utilized in futuristic planning efforts. It is recognized that the IHS Director is concentrating efforts to improve alcoholism programming issues, and is appreciated for these efforts. Recommendations of the NCAI Alcoholism Committee suggest maintenance of a permanent committee to continue addressing alcoholism program conce

PROBLEM:

B. Alcohol and drug abuse continues to be the leading cause of many of the major health problems suffered both on and off-reservations and is also attributable to the high death rate amongst American Indian and Alaskan Native population from illnesses, accidents and suicides. Some of the consequences of alcohol and drug abuse are child and spouse abuse, violent crimes and orphaned children. Consequences such as these are devastating to all of society.

Almost half our nation's American Indian and Alaskan Native population are under the age of 18 years. They are being exposed daily to the devastating ramifications of alcohol and drug abuse without adequate education/prevention experiences that would teach/allow the youth to choose not to drink or use mood altering drugs. This age group of American Indian and Alaskan Native youth are growing to adulthood with the attitude prevelent in society that it is alright to drink/use, thereby perpetuating the problem from generation to generatio

The human and financial needs are incalculable, and, although the Indian Health Care Improvement Act authorizes money for treatment little of these financial resources go to efforts designed to prevent alcohol and drug abuse, and, there has been little or no focus on our youth. While it is difficult to calculate the costs of prevention and education, common sense would dictate that the cost of doing something about the problem will be much less expensive than costs of alcohol related diseases, child and spouse abuse, incarcerations, court costs, public assistance and unemployment due to alcohol and drug addiction.

CONCLUSION:

B. Currently approximately 1% of the authorized funds within the Indian Health Service budget go to efforts designed to prevent alcohol and drug abuse This amount is grossly inadequate in that our Indian youth ages 18 and under constitute 40% of the total Indian population. Educational facilities which serve Indian youth, BIA, Contract, Public and Private schools are rendered inactive in the delivery of prevention, intervention and treatment of alcohol and drug abuse due to the lack of available funds to these organizations for these expressed purposes.

Professional personnel who come in contact with Indian youth are grossly undertrained in the area of alcohol and drug or substance (inhalant) use, prevention, intervention and treatment.

The Indian Health Care Improvement Act authorizes the United States Secretary of Health and Human Services to make contracts to Indian Tribes for establishement and operation of Indian Alcoholism Treatment Programs. Such Indian Health Service supported treatment programs all but ignore the 40% of the Indian youth population as is evident by the existence of only two treatment programs for Indian juveniles. Indian Health Service in practice has not recognized the need for prevention, intervention, and treatment of alcoholism and drug abuse. Indian Health Services currently authorizes only 1% of its monies to be spent on alcohol and drug abuse for our Indian youth, as stated earlier.

The above situations are perpetuated by the lack of acceptance of responsibility for the problems by State and Federal funding sources and the fact that Congress continually ignores the problem.

The maximizing of prevention, intervention, and treatment programs and educational experiences targeted toward Indian youth shall have the long-term productive and positive social effect of further aiding the Indian population toward self-determination, which is the stated policy of the current Administration. To this end, funds should be solicited from other sources, such as private organizations and State legislatures or agencies, and communicative and colloborative efforts should be made in pursuit of this goal.

IT IS RECOMMENDED THAT THE NATIONAL CONGRESS OF AMERICAN INDIANS take initiative and priority in supporting H. R. 6169, the Juvenile Indian Alcohol and Drug Abuse Act, and support the creation and development of alcohol and drug abuse programs in the following manner:

1) By providing information, encouragement, and support to Tribal groups and other interested and concerned organizations that would allow their input and support of H. R. 6169, the Juvenile Indian Alcohol and Drug Abuse Act, introduced September 7, 1984, by Congressmen Daschle and Bereuter;

2) Assist in coordinating and activating efforts with other national Indian organizations and Indian youth groups so as to assure a unified Indian voice to State and Federal government officials on the issue of alcohol and drug abuse prevention, intervention, and treatment programs for Indian youth;

3) Support and encourage Tribal efforts which target alcohol and drug abuse prevention, intervention, and treatment of Indian youth and encourage Tribes and Tribal groups to seek State and Federal legislative resolutions and funding for these programs;

4) Encourage and activate the efforts of Indian youth support services, organizations, tribal programs, and all educational facilities which serve Indian youth in organizing and implementing alcohol and drug prevention, education, and intervention programs for Indian youth;

5) By recognizing the endorsing the National Indian Social Workers Association Resolution 84-4, supporting passage of H. R. 6169;

6) Support the Tribal requests of Indian Health Service to substantially increase the 1% authorization of funds to a level sufficient to meeting the needs and establishment of Indian youth alcohol and drug abuse programs.

This Position Paper on Alcohol and Drug Abuse is respectfully submitted by the Alcohol and Drug Abuse Committee of the National Congress of American on September 13, 1984:

Caleb Shields

Caleb Shields, Co-Chairman
Tribal Councilman
Assiniboine and Sioux Tribes
of Fort Peck

Harry R. Gilmore

Harry R. Gilmore, Co-Chairman
NCAI Area Vice President
Muskogee Area

The 41st Annual Convention of the National Congress of American Indians held at Spokane, Washington during September 10-14, 1984, does hereby approve the above recommendations submitted and presented by the National Congress of American Indians Alcoholism and Drug Abuse Committee.

ASSOCIATION ON AMERICAN INDIAN AFFAIRS, INC.
95 MADISON AVENUE NEW YORK, N. Y. 10016

STATEMENT OF STEVEN UNGER, EXECUTIVE DIRECTOR

&

JERRY FLUTE, ASSISTANT DIRECTOR FOR
COMMUNITY DEVELOPMENT

ON BEHALF OF THE

ASSOCIATION ON AMERICAN INDIAN AFFAIRS, INC.

DELIVERED BEFORE THE

COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

HEARINGS ON H.R. 1156
INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT

OCTOBER 24, 1985

ACCOMPANIED BY:
JACK F. TROPE, STAFF ATTORNEY

Mr. Chairman and members of the Senate Select Committee on Indian Affairs, it is an honor for us to be here today to testify on behalf of the Association on American Indian Affairs, Inc.

The Association is a national citizens' organization headquartered in New York City and dedicated to American Indian and Alaska Native rights. Policies and programs of the Association are formulated by a Board of Directors, the majority of whom are American Indian and Alaska Native. The Association is an independent organization, entirely supported by its approximately 50,000 members and contributors, Indian and non-Indian.

I am Steven Unger, Executive Director of AAIA. My testimony today is offered jointly with Jerry Flute, AAIA Assistant Director for Community Development. We are accompanied by Jack F. Trope, staff attorney.

This Committee is to be complimented for its continuing interest in Indian youth. We are pleased to note that a bipartisan coalition has taken the lead and has joined in introducing H.R. 1156, the Indian Juvenile Alcohol and Drug Abuse Prevention Act. Sadly, such an initiative has not come from the Administration. Congressional attention to the needs of Indian youth is crucial in that administrative agencies often fail to address these needs -- or to respond to Indian tribal concerns, absent such Congressional interest. We hope that this legislation will be enacted expeditiously, as it is an important first step in dealing with the problem of substance abuse among Indian young people.

Before discussing the specifics of H.R. 1156 it is important to quickly pass in review the social and economic factors that contribute to drug and alcohol abuse among American Indians. It would be shortsighted to consider the problem of substance abuse by Indian youths without recognizing the devastating, socially disruptive forces that are a major cause of the problem.

For most Indian young people residing on reservations the prospects for meaningful employment are bleak. Nationally, Indian unemployment on or near reservations has been hovering at about 50% for the last five years, according to BIA statistics. A number of reservations, such as Standing Rock in North Dakota and Pine Ridge in South Dakota, have unemployment rates in excess of 70%. The recent national economic recovery has again bypassed American Indian reservations in most states. For instance, South Dakota's unemployment rate has dropped from 5.5% in 1982 to 5.3% in June of 1985. Indian unemployment in South Dakota, however, has grown from 65% in 1982 to 74% in 1985. Nationally, the unemployment rate for all races has dropped 27% from 1982 to 1985, while the Indian unemployment rate has actually risen 7% during the same period, according to Department of Labor and BIA statistics.

The job opportunities that do exist for young American Indians and Alaska Natives often do not provide the economic or personal incentives that encourage achievement and reward educational accomplishments. In January of 1985, the BIA reports, 77% of employed Indian people on reservations were earning less than $7,000 per year. The average U.S. House of Representatives page -- typically a student in his or her junior year in high school -- earns $9,882 per year, 42% more than what over three-quarters of adult American Indians earn on reservations.

The impact of prolonged periods of high unemployment and the complete lack of economic and job opportunities for American Indians is staggering in human terms. An empirical study prepared for the Joint Economic Committee of Congress a few years ago found that a 1% increase in the national unemployment rate sustained over a six-year period is responsible for a 1.9% increase in deaths from cirrhosis of the liver, a 4.1% increase in suicides, a 5.7% increase in homicides and a 4.0% increase in state prison admissions.

The Joint Economic Committee formulated its conclusions by analyzing the U.S. population with a base unemployment rate of 4.9%. With unemployment rates exceeding 50% on a majority of Indian reservations for years, it can cautiously be inferred from the Joint Economic Committee report that the American Indian population would be expected to have astronomically high rates of suicide and homicide, epidemic occurrences of cirrhosis of the liver, and a majority of the Indian population residing in state prisons. It is a tribute to the strength and determination of Indian communities that these pathologies, devastating as they are to Indian tribes, still do not approach the magnitude that would be expected in the general U.S. population when national unemployment is high or rising.

Statistics of course cannot measure the family stress and wounds to body and soul that Indian people experience because of prolonged unemployment. Improving the economic climate of reservations is a vital step in reducing the alcohol and drug abuse problems of Indian youth.

The thrust of this bill is to provide services for Indian youth. One needs always to bear in mind that there are immense differences between American Indian tribes based on culture, geography, history (including the history of Indian-white relations for each tribe), degree of assimilation, language, and so forth -- not to mention the difference between Indians and non-Indians.

Culturally, Indian children are profoundly different from their non-Indian contemporaries. Indian children growing up sometimes experience discrimination by non-Indians because they look and often behave differently. Educational materials used in the classroom are notorious for their frequently pejorative portrayal of Indian life. What self-image of the child and the tribe is conveyed? What expectations for adult life does the child absorb? Does the child feel welcome in the school or alienated from it?

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The situation of American Indians has sometimes been characterized as "aliens in their own land." Indian children grow up having to live in two worlds, the enduring traditional tribal world, and the world of America in the 1980s. Indian leaders (and non-Indians working in the field of chemical dependency) often speak of the "conflict between the cultures" as creating great problems for Indian youth. We know well, and indeed this bill is in part a response to this knowledge, that these problems all too often manifest themselves in alcohol and substance abuse. The more this Committee's initiative with H.R. 1156 is sensitive to these cultural differences, the more effective it will be.

A stable and encouraging family environment with parental care and supervision obviously contributes to healthy and drug-free Indian youth. Unfortunately, for approximately 20,000 Indian children -- thousands under ten-years old -- even their education means the absence of normal family life, for today they are sleeping in BIA boarding schools and dormitories.

Many youth counselors are convinced that boarding schools contribute to alcohol and drug problems among Indian youth. The anachronistic boarding schools, the product of a now-discredited era of racism and paternalism, continue a system that contributes to alcoholism and makes effective counselling impossible because of the separation of Indian children from their families. How many more Indian youngsters must suffer in the twilight paroxysm of the boarding schools before the federal government finally assures day schools for all Indian families who want them?

The absence of social programs and recreational facilities on Indian reservations means that Indian and Alaska Native youngsters grow up in an environment where drug and alcohol abuse may seem to be their only release from a world that sometimes must seem determined to beat them down.

A recent AAIA study, conducted on fifteen reservations in Nebraska, South Dakota and North Dakota, found that an acute lack of services for Indian youth was a deep concern of tribal leaders. Eighty-seven percent of the tribes surveyed indicated that their reservations had few cultural and social activities for young people. Those activities which are available, such as sports, are largely confined to the school year, and summertime leaves youths without places to go for recreation.

Summer sports that often do exist in more well-to-do communities, such as Little League baseball, often require private sponsors to purchase uniforms and equipment. But in a depressed economic environment there are few Indian merchants with extra cash to support Little League baseball. We remember a few years ago when a group of Navajo Little Leaguers, often being rejected in their pleas for help from local non-Indian merchants in Farmington, New Mexico, washed cars and did odd jobs, and then in desperation turned to our Association in New York for help -- just for gas money so their coach could drive them to the games. An AAIA grant of $300 made possible a constructive summer activity for these Navajo youngsters, allowing them to play as equals with their non-Indian peers.

The majority of tribes surveyed expressed a need for year-round, constructive activities for their young people. Indian children, like non-Indians, need outlets and activities that build their self-esteem, not destroy it. In our interviews, a sense of frustration was frequently expressed by tribal leaders who felt hindered in their attempts to provide alternatives for youth because of inadequate resources. Tribal community members were discouraged because the programs that do work to prevent youth alcoholism and drug abuse, such as youth summer camps, Boy Scouts and Girl Scouts, a local YMCA or athletic leagues, are underfunded, scheduled for elimination, or just do not exist.

The results of our study indicate a clear relationship between the presence of drug and alcohol abuse and the absence of youth programs and activities on reservations. A survey of reservations in other parts of the country would undoubtedly yield similar results. (With our testimony, we are submitting a copy of our study, which addresses a wide range of issues relating to Indian youth. We ask that it be incorporated into the record of these hearings.)

Given the background upon which the question of substance abuse must be considered, perhaps what is surprising is not that there is a substance abuse problem on Indian reservations, but that so many Indian youths do not fall into the alcohol and drug trap.

Nonetheless, the statistics indicate a serious problem and provide strong evidence that legislative initiatives addressing substance abuse among Indian youths, and its underlying causes, are sorely needed. A 1984 study, prepared by Colorado State University and based on a sample of 10,000 Indian students on forty reservations, indicates that 51.8% of Indian adolescents are engaged in moderate to heavy alcohol or drug use. In comparison, 23.3% of urban non-Indian students are engaged in similar activities.

If the general U.S. population had the same percent occurrences of heavy drug and alcohol use as Indian adolescents, AAIA calculates there would be 36.5 million people in the U.S. with debilitating and destructive drug and alcohol habits.

The latest U.S. Indian Health Service statistics indicate that Indian mortality related to alcoholism is 5.6 times higher than the national average. Suicide rates for Indian youths between 15 and 24 years of age are 2.3 times that of the national average. The statistics do not indicate what percentage of the suicides are drug or alcohol related, but it seems safe to assume that at least some of the self-inflicted deaths are associated with substance abuse.

The drug and alcohol problems of Indian youth have been at epidemic levels for many years. The Reagan Administration has publicly encouraged Indian self-determination, but when tribes attempt to formulate programs and legislation that attack drug and alcohol abuse, the Administration withholds support or proposes further cutbacks. The reauthorization of the Indian Health Care Improvement Act, which was vetoed by the President last fall, had important provisions which addressed the problems of youth alcohol and drug abuse.

The Administration has gone beyond passive resistance to Indian alcohol and drug prevention and treatment programs by consistently submitting budgets with significant reductions in those Indian community-based programs that would help tribes effectively deal with alcohol and substance abuse.

The constant attempts by the Administration to eliminate the Community Health Representative program of the IHS is but one example. Fortunately, this Committee and the Congress as a whole have listened to Indian tribes (and AAIA) and consistently restored funds to the demonstrably-effective Community Health Representatives. The Administration's FY 1986 budget for IHS again proposes a 5% reduction in real dollars in Indian alcohol prevention programs and lower funding levels for health clinics and public education programs that have been successful in preventing alcoholism and drug abuse. The Administration seems to feel that models based on comparatively well-to-do urban health facilities are adequate to meet the needs of a rural, impoverished, culturally unique, Indian population.

The social costs of not providing drug and alcohol prevention and treatment programs for Indian youth should be evident. When Indian children misuse drugs and alcohol they are more likely to be involved in juvenile mischief, anti-social or self-destructive activities, criminal acts or be admitted to clinics and hospitals for emergency treatment. Society foregoes the contributions of a productive member of the community when that individual is ravaged by drugs and alcohol. Education, treatment and prevention measures will reduce the costs to society in the long run if Indian children are discouraged from using drugs and alcohol today.

Following is our analysis of the provisions of H.R. 1156 and our recommendations for improving the bill based on our experience in working with Indian tribes.

TITLE

We recommend that the word youth be substituted for juvenile throughout the bill. The word juvenile has acquired a negative, legalistic, connotation in popular usage which should be avoided. (For example, an Indian youth studies drums; an Indian juvenile is a delinquent.)

TITLE I - INTERDEPARTMENTAL AGREEMENT

The coordination of existing resources can hardly be faulted. The §101 Washington-based interagency agreement, however, should serve to facilitate locally-based, tribal-specific agreements rather than attempt to definitively resolve individual agency conflicts. It should provide general guidelines to be utilized at the local level, but each locality must be given the flexibility to structure the system to meet its unique needs. Thus, §102 is the more important section in Title I, although, by itself, it is inadequate.

§102 presently contemplates only a coordination of existing resources. This is not enough. §102 should be amended in Committee to institute a planning process -- an evaluation of what is required for an effective alcohol and drug abuse prevention program and a plan for reaching that goal. A provision for contracting in the manner of the Indian Self-Determination and Education Assistance Act (P.L. 93-638), 25 U.S.C. 450 et seq., should be available to tribes or inter-tribal organizations (with approval by the individual member tribes) who wish to design the programs directly. The BIA agency superintendent, BIA education superintendent, and the IHS service unit director should be responsible for developing these plans on a local basis in those instances where tribes request a §102 agreement and are unable to develop such plans themselves.

Another salutary amendment to this section would be a provision in the bill that tribes specifically receive notice of their right to request that an agreement be prepared. Too often the executive branch fails to inform tribes of Congressionally-mandated rights of this sort without specific legislative direction.

Moreover, tribes should have the option of deciding whether the agreements should include the tribe or whether an intra-governmental agreement between the agencies would be appropriate. This option should be included because some smaller tribes may not have the resources available to them to protect their interests in negotiating an agreement involving the BIA and IHS and might be reluctant to request such an agreement for that reason.

Finally, while tribes presumably would be permitted to contract to administer those services contemplated by this Title pursuant to §102 and §103 of Public Law 93-638 (25 U.S.C. §450f and §450g), it would be useful to specify in this bill that a tribe may modify those services for which it contracts in order to meet local needs. Tribes have often complained of rigidity in the 93-638 process. This provision would ensure maximum flexibility for those tribes with the capacity to shape their own programs and dovetail with the planning provisions that we have suggested. It would be consistent with the President's statement on Indian policy of January 1983 in which he committed his Administration to "a flexible approach which recognizes the diversity among tribes and the right of each tribe to set its own priorities and goals."

TITLE II - EDUCATION

A. In-School Instruction

We support §204(a) which requires BIA and BIA contract schools to provide a program of instruction regarding alcohol and drug abuse for students in grades K-12. The BIA needs to be prodded by Congress if it is to fulfill this responsibility. Earlier this year, the Standing Rock Sioux Tribe brought to our attention that an Act passed by Congress on May 29, 1886 (24 Stat. 69) already requires such instruction. The pertinent part of that Act is quoted in the BIA Manual (62 BIAM 5.4). That Congress in 1985 must direct the BIA in this legislation to do what it required the BIA to do a hundred years ago is a good example of how the Bureau often thwarts the will of Congress. We are pleased to see Congress again instructing the Bureau and hope that it will not take another five generations of Indian children before the BIA acts on your instructions.

We also support §204(b) which encourages family participation in the instruction contemplated by this section.

We believe that a clause should be added to this section requiring that the program developed be tribally-specific with local input. The Senate variation of this bill, S. 1298, includes such a provision. We urge this committee to amend H.R. 1156 in a similar fashion.

We also believe that a section should be added to this title to address the issue of drug and alcohol curriculum in public schools on or near reservations which serve significant numbers of Indian students. However, we recognize that mandatory alcohol and drug abuse instruction limited to Indian students in public schools could lead to the ridicule of Indian students by their non-Indian peers. Thus, a mandatory requirement that Indian students in public schools on or near the reservation must receive alcohol and drug abuse training may not be desirable. Nonetheless, the resources for providing such instruction should be made available for use where Indian parents so desire. Accordingly, we believe that §304 of the Indian Elementary and Secondary School Assistance Act (P.L.81-874), 20 U.S.C. §241cc -- the statute authorizing distribution of Johnson-O'Malley funds -- should be amended to permit, but not require, the use of Johnson-O'Malley funds to develop and implement curriculum relating to alcohol and drug abuse. This,of course,should be at the initiative and discretion of Indian parents with children in the affected school system.

We support the amendment to §304 of P.L. 81-874 already included in H.R. 1156 which would permit Johnson-O'Malley funds to be used for "the training of counselors at schools eligible for funding in counseling techniques relevant to alcohol and drug abuse."

We also believe that the bill should be amended in Committee to provide explicitly that the curriculum include materials on inhalants and Fetal Alcohol Syndrome. In our study of fifteen tribes, many said that the use of inhalants on their reservations was a problem. 80% said that inhalants are used and several respondents mentioned that the inhalants seem to be more in use by the younger children, ages 8-12, probably because inhalants are easier to obtain. The inhalants mentioned the most frequently included correction fluids, thinners for these substances, office machine chemicals, gas, spray paint, Lysol spray, and other household products for cleaning. According to 1980-81 data from Western Behavioral Studies, 30% of Indian youths in grades 7-12 have tried inhalants. (A survey of non-Indian city youth revealed that 10% had tried inhalants.) Thus, we believe that this legislation should specify that inhalants must be included in the education curriculum. Otherwise they may be ignored in developing the program, given the relatively low incidence of such use in the general populace.

Likewise, Fetal Alcohol Syndrome (FAS) is increasingly a problem on reservations. Recently, an IHS physician told one tribe that, if the present trend continues, virtually all of the next generation of children on the reservation will suffer from Fetal Alcohol Syndrome. Inclusion of FAS materials is specifically mandated by §301 of this bill in regard to the training materials to be developed. Explicit mention of FAS is desirable in this section as well to ensure that this topic is included in the school curriculum.

Finally, there should be a provision added to §201 of this bill providing that the program should include a mechanism for intervening with individual students at risk, as well as general instruction for all students.

B. Summer Recreation Programs

If this legislation is accurately to be classified as a preventive approach to the problem of substance abuse, recreation and counseling programs for Indian youth on reservations must be included in this bill. We strongly support the concept in §205 of this bill and commend this committee on its inclusion in this bill. This section provides that BIA schools and schools operated by tribes under contract to BIA, as well as other public and private facilities that can be made available, should be utilized for summer recreational programs and salaried coordinators for these programs should be provided as needed. This section is not included in S.1298 and we urge this Committee to retain and improve §205. First, we believe that a provision for tribal input into the design of these programs should be included in the bill. Second, the programs should be made available on a year-round basis. Moreover, drug and alcohol information should be made available as part of such programs.

The evidence from our study of fifteen reservations in the northern Great Plains indicates that an adequate youth recreation provision is a crucial component of an alcohol and drug abuse prevention bill. There is perhaps no better preventive medicine than constructive activities for youth.

TITLE III - FAMILY AND SOCIAL SERVICES

We generally support the creation of a moderate training regimen for a wide range of individuals who work with Indian youths, as well as all interested members of the Indian community. However, we believe that the training provisions in H.R. 1156, as currently drafted, are not sculpted as well as they could be.

First of all, we suggest that explicit language be included in this title providing that training materials be culturally sensitive to the unique culture and living conditions of Native Americans in terms of child development, sociology, psychology, preventive strategies and family life. Training in child development generally should be an integral part of the training materials.

Secondly, as we suggested in regard to school curricula, methods of treating inhalant abuse should be part of the program.

Thirdly, we believe that training should be provided in local Indian communities, whenever practicable, at low or minimal cost, and as part of an integrated program. S. 1298 includes a section mandating that training be provided in this manner and we believe that these guidelines would increase the possibility that the training will be meaningful and reach those persons who most need it.

Finally, we believe that the mandatory training requirement covers certain people who would benefit only marginally from the training, such as high level BIA and IHS personnel not involved in the providing of direct servicesto youths. We would prefer to see available resources utilized instead to develop two additional types of training materials in addition to the "basic materials." First, a more extensive set of materials should be developed to train those who plan to work as full-time youth counselors. In AAIA's study of the Great Plains reservations, many tribes indicated that they desired more trained personnel to provide counseling services to their youth. Although most tribes had ongoing programs for the treatment of alcoholism, only two had programs specifically oriented to youth. Some tribes told us that they fear that their alcohol programs are not as successful as they could be because they do not have skilled and trained counselors who know how to intervene specifically with youths. Thus, a training program should be developed that would be more rigorous than the basic program, but abbreviated in scope as compared to that offered by a college degree program. This would help meet the need reported to us by many reservations.

Secondly, a set of materials dealing with alcohol and drug abuse prevention and parental skills might be developed, perhaps in pamphlet form, which would be less extensive than the "basic training" materials, and made available for distribution to any interested member of the Indian community. Community awareness and training for prospective parents is likely to help reduce the incidence of substance abuse.

These amendments would establish a broad yet focused training system which we believe will provide a change for the better for Indian young people.

TITLE IV - LAW ENFORCEMENT

The concept of emergency shelters in lieu of incarceration for Indian youths is an idea worth trying. Moreover, the structure of the program in H.R. 1156 is far better than the structure provided for by S.1298.

We particularly endorse section 402(a)(2) which provides that guidelines to be developed and placement preferences to be established under this Title "shall not supersede any tribal law." The concept of self-determination has been the cornerstone of federal Indian policy for this generation. The Indian Child Welfare Act, for example, explicitly permits Indian tribes to set their own priorities for the foster care or adoptive placement of Indian children which supersede the priorities set in that Act. It is precedent for permitting tribes to modify federally-set guidelines applicable to non-tribal judicial proceedings and we are pleased to see that this bill is following that precedent.

Secondly, we concur with the approach of H.R. 1156 which provides that "households of Indian families will be compensated to serve as temporary emergency shelters..."We believe that a community-based program utilizing appropriate Indian families is preferable to a program administered by the federal goventment.

Thirdly, we agree wholeheartedly with the sponsors of this bill that non-prison alternatives for the placement of youths should be preferred.

Nonetheless, we have a number of suggestions for improving this Title. Tribes should have the ability to exercise more control over the program should they choose to do so. Although §402(c) requires that the tribe must approve each shelter, it also provides that the BIA will develop guidelines for licensing the shelters. A uniform set of BIA standards for such shelters may serve to inhibit rather than encourage their establishment. Tribes have different needs and resources. Provision should be made for tribes to establish their own set of standards for such shelters that would, upon adoption, supersede BIA regulations.

In addition, we suggest placement with the juvenile's own family as one of the preferred placement options. Indian youths with an alcohol or drug abuse problem are often best treated as part of a family network and not in isolation. Trained social services workers can be utilized to work with the family and the court-referred youth where necessary. The court may, of course, place a youth elsewhere when it would benefit the youth or where the community requires alternative placement. However, the programs established by this bill should reach out to families, including the Indian extended family, wherever possible. By including family placement as one of the preferred options, Congress will send a clear message that Indian families may feel encouraged, not threatened, by a new federal program. Similarly, the courts need to be encouraged to use the Indian family as a resource.

TITLE V - JUVENILE ALCOHOL AND DRUG ABUSE TREATMENT AND REHABILITATION

We think that the study and treatment program contemplated by Title V is useful and would be most beneficial. We have some suggestions for improving the Title, however.

First, there should be a provision expressly mandating consultation with Indian tribes. This is present in S.1298 and we urge this Committee to similarly amend this bill.

Second, we believe that the bill should specifically provide that the study be conducted from the ground up -- in other words, that the needs assessment be developed at the local level, after which a national study would be developed building upon the local studies. We think that such an approach would help assure that the Administration and Congress have available to them solid information that respects, rather than obscures, the cultural integrity and specific needs of each Indian tribe.

Finally, there should be a provision allowing that the local studies may be contracted out to Indian tribes or multi-tribal organizations. This approach would help assure that programs are crafted to meet the actual needs of individual Indian tribes.

TITLE VI - DEFINITIONS, EFFECTIVE DATE, AND AUTHORIZATION OF APPROPRIATIONS

A. Definitions

The definition of "Indian" should be expanded to include those who are eligible for membership in a tribe but who are not presently members. In some cases, youths may not have actually applied for membership even though they may qualify for it. The definition of "Indian child" in the Indian Child Welfare Act (P.L. 95-608) recognizes the need for an expanded definition when dealing with youth.

The definition of "Indian tribe" also needs amendment. The present definition as it relates to Alaska includes the village and regional for-profit corporations established by the Alaska Native Claims Settlement Act (ANCSA) (P.L. 92-203). However, those corporations do not provide the type of services covered by the bill. It would be more appropriate to refer to the regional non-profit Native associations identified in section 7(a) of ANCSA, 43 U.S.C. §1606(a).

We would like to see the definition of juvenile in the bill expanded to include eighteen-year-old youths. The present definition may serve to deny certain high school students and other youths access to services which would be beneficial to them.

B. Funding

We believe that the provision authorizing a $5 million appropriation is too limiting. If this bill is to be meaningful, adequate sums to implement this bill must be appropriated on a regular basis. Perhaps an amendment should be made to this Title saying that it is the sense of Congress that "such sums as may be necessary, but not less than $5 million..." be appropriated until such time as Congress is satisfied that these programs are having their intended effect.

Moreover, Congress should not view this bill as a cure-all. Other funding sources must continue to be made available to tribes and their availability should be expanded wherever possible.

CONCLUSION

We hope and trust that you will carefully consider our recommendations for improving H.R. 1156. The sponsors of this bill deserve credit for taking the lead in introducing this bill and spurring Congress into action. This Committee has in the past taken a leading role in developing legislation establishing programs for Indian families and youth and the interest and concern of Congress and this Committee in this bill continues to provide hope to Indian tribes that they will be provided with the tools necessary to help make a better life for themselves.

Thank you for inviting us to appear before you on H.R. 1156. We look forward to working further with this Committee and the Congress to bring such much-needed reforms to reality.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON D.C. 20201

JUL 29 1985

The Honorable John McCain
Chairman
Republican Task Force on Indian
  Affairs
House of Representatives
Washington, D.C.   20515

Dear Mr. Chairman:

Thank you for your letter regarding concerns of the Republican Task Force on Indian Affairs about the "epidemic abuse of drugs and alcohol among juvenile members of Indian tribes." Certainly we share your concerns about this very serious health problem among Indian youth.

Your letter suggested that the Department of Health and Human Services (DHHS), through the Indian Health Service (IHS) units, enter into working agreements with local Bureau of Indian Affairs (BIA) agencies and Indian Tribes, for the coordination of their respective efforts. I would like you to know that working agreements between the BIA agency offices and IHS Service Units and between the IHS Service Units and local tribes are already in existence in many locations.

I have no objection, however, to entering into a general agreement with the Secretary of the Interior and will ask the IHS to develop an appropriate document for this purpose. Furthermore, since 1972 when 50 Office of Economic Opportunity-funded Indian alcoholism programs were transferred to the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), National Institute on Alcohol Abuse and Alcoholism (NIAAA) and an Indian Desk for Support and Liaison was established, a major funding policy was implemented which required all applicants to obtain memorandums of agreement and commitments from all applicable resource agencies in all local Indian communities. The requirement for these agreements has been continued following transfer of the alcoholism programs from the NIAAA to the IHS. They are an integral part of the management of local alcoholism programs and they effect considerable coordination between IHS and other interested parties and organizations.

You have also suggested that the DHHS should correlate existing Federally financed studies on Indian alcoholism to formulate a scientific baseline for juvenile programs. The IHS Alcoholism Program Branch has responsibility for accomplishing such an analysis and correlation and the process has begun. The National Clearinghouse for Alcohol Information has provided copies of related documents and a list of references to facilitate this work.

Your letter further suggested that ADAMHA coordinate existing treatment programs and grants with IHS to focus resources on an Indian juvenile program. The IHS and the ADAMHA/NIAAA have coordinated their efforts closely for some time. However, under terms of the Alcohol and Drug Abuse and Mental Health Services (ADAMHS) Block Grant, only Indian tribes and tribal organizations which had been receiving alcohol or drug abuse treatment grants or contracts directly from the Department in Fiscal Year 1980 are eligible to apply for direct funding for alcohol or drug abuse treatment and prevention services through the block grant mechanism. Eligible tribes may choose to apply for block grants or for direct services funding through the IHS. As of the end of June, the vast majority of tribes and tribal organizations have chosen funding from the IHS. Of the Indian organizations that are eligible, only two have elected to receive funding from the ADAMHS Block Grant. The ADAMHA also continues to support research into alcohol, drug abuse, and mental health problems of American Indians and Alaska Natives as part of its overall research portfolio concerning minority health problems.

The Department supports the intent of legislation which would initiate a program aimed at arresting alcohol and drug abuse among Indian youth. We agree that the interagency cooperation called for in H.R. 2624 and H.R. 1156 bills is essential if meaningful success is to be achieved. In fact, we are already effecting this cooperation. We believe, therefore, that legislation is not needed to ensure such efforts. We do oppose Sec. 2 of H.R. 2624 which would provide for statutory establishment of an Office of Alcohol and Drug Abuse with a mandatory organizational structure. The placement of administrative responsibility for program efforts and the establishment of an organizational structure for carrying those efforts forward are better handled by departmental management staff closest to the problem. We believe that these management staff know best how to channel funding and staff resources to obtain the most effective and efficient results.

I appreciate your continued interest in the Department's Indian substance abuse programs. A similar letter is being sent to each Task Force member.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

RESPONSE TO CONGRESSIONAL REQUEST FOR DATA ON AMERICAN INDIANS/ALASKAN NATIVES

Prepared for:

National Institute on Alcohol Abuse and Alcoholism
Alcohol, Drug Abuse, and Mental Health Administration
Department of Health and Human Services

Prepared by:

Alcohol Epidemiologic Data System
CSR, Incorporated
1400 Eye Street, N.W., Suite 600
Washington, D.C. 20005

January 22, 1985

The data presented in this report were generated from data bases available in the Alcohol Epidemiologic Data System (AEDS). The AEDS is operated by CSR, Incorporated under a contract with the National Institute on Alcohol Abuse and Alcoholism.

The analyses presented in this report were conducted in respose to a request from Congressman Tom Daschle in a December 17, 1984 letter to Dr. William Mayer of the Alcohol, Drug Abuse, and Mental Health Administration. Using data available in the AEDS, CSR was able to respond to the following 12 items requested.

1. Number and percent distribution of deaths by age of American Indians/Alaskan Natives and all other races. [Tables 1 and 4]

2. Age-adjusted mortality rates for American Indians/Alaskan Natives and all other races. [Table 5]

3. Leading causes of death among American Indians/Alaskan Natives and all other races. [Tables 2 and 3]

4. Age-adjusted accident mortality rates for American Indians/Alaskan Natives and all other races. [Tables 5, 6 and 7]

6. Homicide deaths and death rates for American Indians/Alaskan Natives and all other races--age-specific. [Table 8]

7. Suicide deaths and death rates for American Indians/Alaskan Natives and all other races--age-specific. [Table 9]

8. Alcoholism deaths and rates for American Indians/Alaskan Natives and all other races--age-specific. [Table 10]

9. Drug-related deaths and death rates for American Indians/Alaskan Natives and all other races--age-specific. [Table 11]

14. Number of federally-funded alcohol and drug abuse prevention and treatment programs for juveniles in the United States. [Table 13]

15. Number of admissions of juveniles into federally-funded alcohol and drug abuse prevention and treatment programs--one-year period. [Table 12]

16. Number of admissions of American Indian/Alaskan Native juveniles into federally-funded alcohol and drug abuse prevention and treatment programs--one-year period. [Table 12]

17. Number of federally-funded alcohol and drug abuse prevention and treatment programs for juveniles on reservations and in Alaskan Native villages. [Table 14]

For those items requesting race-specific data, we have chosen to present comparisons of American Indians/Alaskan Natives and all other races, rather than comparisons of American Indians/Alaskan Natives and all races. The comparisons presented provide a cleaner comparison between the two groups, since American Indians/Alaskan Natives would be included in both groups for the latter type of comparison. For some items, the available data allowed for only an indirect, but meaningful, response. Therefore, the reader should interpret all tables presented in light of the narrative information accompanying each table.

The AEDS does not contain the data necessary to respond to the following five items requested:

5. Age-specific accident death rates for American Indians/Alaskan Natives and all races by (a) alcohol- or drug-related and (b) non-alcohol or non-drug related causes. [Data on alcohol involvement in fatal motor vehicle accidents are available in the Fatal Accident Reporting System, a data base which AEDS obtains from the Department of Transportation. However, the information in this data base does not code fatalities by race. It would be possible to analyze alcohol-related motor vehicle fatalities comparing counties with and without Indian reservations. This analysis is not directly responsive to the request and it is not clear how meaningful it would be, but CSR is prepared to conduct such an analysis if requested.]

10. Fetal alcohol syndrome cases among American Indians/Alaskan Natives and all races. [Data are not available in the AEDS.]

11. Spouse and child abuse cases among American Indians/Alaskan Natives and all races. [Data are not available in the AEDS.]

12. Violence as a cause for hospitalization among American Indians/Alaskan Natives and all races. [Data are not available in the AEDS.]

13. Violence as a cause for emergency or clinical care among American Indians/Alaskan Natives and all races--age-specific. [Data are not available in the AEDS.]

A narrative discussion of presented tables follows.

Tables 1-11

These tables present mortality data for American Indians/Alaskan Natives (AI/AN) and for all other races. These data are from the 1980 detailed mortality tapes compiled and published by the National Center for Health Statistics (NCHS). This data base contains demographic information and a code of the underlying cause of death as certified on the death certificate for each death occurring in the United States during 1980. In conducting analyses of mortality data, CSR examined only deaths of U.S. residents. 1980 was selected as the year for analysis for two reasons:

1. 1980 is the most recent year for which the detailed mortality tapes are available for public use, making this the most recent year for which mortality data are available in the AEDS.

2. The calculation of the requested mortality rates required the use of age- and race-specific population figures. The most accurate, recent population figures for age- and race-specific groups are from the 1980 U.S. Census. These population figures were used in the calculation of mortality rates presented in this report.

As requested, the tables in this report include numbers of deaths, age-specific mortality rates, and age-adjusted mortality rates. In addition, certain of the tables present proportionate mortality ratios (PMRs). For each age/race category, the PMR indicates the percent of all deaths for that group which are represented by a particular cause of death being reported. The PMR is, thus, an additional indicator of the prevalence of a particular cause of death in the defined age/race group.

For those tables presenting data on specific causes of death, the following definitions (based on the Ninth Revision of the International Classification of Diseases) apply:

Motor vehicle accidents (E810-E825)

All other accidents and adverse effects (E800-E807, E826-E949)

Suicide (E950-E959)

Homicide and legal intervention (E960-E978)

Alcohol-related causes:

Alcohol psychoses (291)
Alcohol dependence syndrome (303)
Chronic liver disease and cirrhosis (571)
Accidental poisoning by alcohol, not elsewhere specified (E860)
Non-dependent abuse of drugs (alcohol) (305.0)
Alcoholic polyneuropathy (357.5)
Alcoholic cardiomyopathy (425.5)
Portal hypertension (572.3)
Excessive blood level of alcohol (790.3)

Drug-related causes:

Drug dependence (304)
Non-dependent use of drugs (except alcohol) (305, except 305.0)
Polyneuropathy due to drugs (357.6)
Accidental poisoning by analgesics, antipyretics, and antirheumatics (E850)
Accidental poisoning by barbiturates (E851)

Accidental poisoning by other sedatives and hypnotics (E852)
Accidental poisoning by tranquilizers (E853)
Accidental poisoning by other psychotropic agents (E854)
Accidental poisoning by other drugs acting on central and
autonomic nervous systems (E855)
Suicide and self-inflicted poisoning by solid or liquid substances
(drugs) (E950.0-E950.5)
Poisoning by solid or liquid substances, undetermined whether
accidentally or purposefully inflicted (drugs) (E908.0-980.5)

Alcohol- and drug-related cause of death may be underreported in the data contained in the NCHS tapes and, therefore, in the analyses presented in this report. This is likely because alcohol and drug abuse are stigmatized in our society. For this reason, there may be some tendency for physicians, medical examiners, or coroners certifying cause of death to err on the side of not mentioning alcohol or drugs as contributing to the underlying cause of death. For example, a death from overdose of heroin might be certified as a cardiac or respiratory arrest, simply to avoid embarrassment to the surviving family.

For this reason, we have counted as alcohol-related causes of death all chronic liver disease and cirrhosis (all 371) and not just chronic liver disease and cirrhosis specifically attributed to alcohol (571.0-571.3). The NIAAA believes that this count provides a more accurate indication of the actual numbers of alcohol-related deaths. Since there is not a similar category of drug-related deaths which might capture more of the presumably "truly" drug-related deaths, the actual numbers of drug-related cases reported may be more of an underreport than is true for alcohol-related causes of death. There is no basis on which to speculate that any underreporting of drug- or alcohol-related deaths might differentially affect numbers reported for AI/ANs as opposed to all other races.

Table 1

This table presents numbers and percents of deaths for all causes, for AI/ANs and all other races by age group, and shows that for all causes of death combined AI/NAs below the age of 55 are more likely than all other races to die. The median age of death for AI/ANs falls in the 55-64 year age category, while the median age of death for all other races falls into the 65-74 year age category.

Tables 2 and 3

These tables present numbers and percents of deaths for each of 25 leading causes of death for each of the two major ethnic groups. These tables include all causes of death; each death is included in one of the categories of cause of death. One of the striking findings from comparison of these two tables is that causes of death which are often considered to be alcohol-related (i.e., motor vehicle accidents, all other accidents, chronic liver disease and cirrhosis, and homicide and legal intervention) rank higher for AI/ANs than for all other races. The causes of death presented in these tables are based on the NCHS "34 causes" recode. More detailed analyses of more specific causes of death can be done upon request.

Table 4

This table presents numbers of deaths and age-specific death rates for all causes of death, for specified age groups and race groups. These data reinforce the data presented in Table 1; for all causes of death AI/ANs below the age of 55 have higher mortality rates. This is a further indication that AI/ANs die at younger ages for all causes of death combined than do all other races.

Table 5

This table presents age-adjusted mortality rates for selected causes of death for AI/ANs and all other races. With the exception of drug-related causes, all causes of death presented in this table have been associated with alcohol abuse. For all of these causes of death (excluding the drug-related causes) the age-adjusted mortality rates are higher for AI/ANs than for all other races. The greatest difference is for "alcohol-related" causes of death.

These age-adjusted mortality rates are derived from more detailed data which are presented in Tables 6-11.

Tables 6-11

These tables present numbers of deaths, age-specific mortality rates and PMRs by race and age for selected underlying causes of death. For all but the drug-related causes of death, these tables indicate that AI/ANs are at greater risk for death than are all other races. The interpretation of Table 11 must take into account the probability that drug-related causes of death (as they appear as underlying causes of death in the NCHS data base) are underreported.

Table 12

This table presents numbers and percents of clients admitted to federally-funded alcohol or drug treatment programs for AI/ANs and all other races in selected age groups. These numbers are total admissions for the calendar year 1981.

The National Institute on Drug Abuse (NIDA) collected these data from all federally-funded drug abuse treatment and rehabilitation programs in the U.S. and outlying areas. Data were reported on the Client Oriented Data Acquisition Process (CODAP) form, completed at both admission and discharge from a treatment program for all clients, regardless of whether services to a particular client were underwritten with federal funding support or not. Attempts were made to reduce multiple counting of individuals by excluding all transfer admissions from the file. Since drug abuse treatment units may treat clients whose primary drug of abuse is alcohol (with or without secondary drug involvement) data from these clients is also represented in the table. The data come from "NIDA Statistical Series, Annual Data, 1981, Data from the Client Oriented Data Acquisition Process (CODAP), Series E, Number 25."

These data are the most recent complete national data available on admissions. The introduction of block grants eliminated certain reporting requirements and data for later years are incomplete or in inconsistent formats.

The data indicate that proportionately more AI/ANs were admitted for alcohol/drug treatment than all other races. Further, the percentages show that AI/AN clients tend to be younger than clients of all other races.

The data reported here are for treatment. CSR is unaware of any data on alcohol or drug prevention programs. More recent data on treatment are available from the National Drug and Alcoholism Treatment Utilization Survey (NDATUS) conducted by NIDA. However, the request was for numbers of annual admissions. NDATUS contains only numbers of clients in treatment on a single sample day, and it would be impossible to reliably compute an estimate of annual admissions from this information.

Tables 13 and 14

The National Drug and Alcoholism Treatment Utilization Survey (NDATUS) which was conducted cojointly by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) in 1979, 1980 and 1982 is the most comprehensive source of information in the United States on the treatment of alcoholism. The data are a census of treatment units with a response rate of about 90 percent. A minority of the treatment units surveyed were primarily prevention rather than treatment oriented.

There are some limitations to the data however. The measures of client age and ethnicity are true point prevalence statistics since information is provided only for the number of active clients on the day September 30, 1982. Yearly figures are unavailable in this data base.

Items 14 and 17 are answered in terms of the point prevalence of alcoholism treatment units and alcohol and drug abuse treatment units providing care to AI/ANs by the age groups serviced. The answer to item 17 restricts the sample of units to those in counties with American Indian reservations. Information could not be obtained which would have allowed the identification of Alaskan native villages.

Table 13

There were 4,233 treatment units surveyed by the National Drug and Alcoholism Treatment Utilization Survey (NDATUS) on September 30, 1982. Units which treated alcohol abuse exclusively numbered 2,729, those which treated both alcohol and drug abuse numbered 1,504. Units which received funds from any of the following sources were considered to be federally-funded: ADAMHA block grant; other ADAMHA program support (including formula and uniform act); other federal funds, e.g., from Federal Prison System, Bureau of Community Health Services, Veterans Administration, etc.; Social Services Block Grant (formerly Title XX); or Public Welfare. The number of alcohol units which received federal funds was 1,454 (53.3 percent of all alcohol units). Units which treated both alcohol and drug abuse numbered 861 (57.3 percent of all units which treated both alcohol and drug abuse).

There were 449 federally-funded alcoholism treatment units which reported that they had one or more AI/ANs in treatment on September 30, 1982. This was 30.9 percent. Alcoholism treatment units which did not numbered 1,005. Alcohol and Drug Abuse units which had treated AI/ANs totaled 192 (22.3 percent) while those that had not totaled 669.

Three age groups were chosen for analysis. These were the following: age 18 and younger; age 19 through 20; and age 21 and older. Units were categorized according to client age. The unit was counted for each age group if one or more persons whose age fell within the age group was in treatment on September 30, 1982. Therefore, the same treatment unit could appear for each of the three age groups.

The number of federally funded alcoholism treatment units which provided treatment to clients age 18 and younger was 556 (38.2 percent), to clients age 19 through 20 was 846 (58.2 percent), and to clients age 21 and older 1,429 (98.3 percent). The number of alcohol and drug abuse treatment units which provided treatment to clients age 18 and younger was 468 (54.4 percent), to clients age 19 through 20 was 541 (62.8 percent), and to clients age 21 and older 821 (95.4 percent). A higher percentage of alcohol and drug abuse as compared to alcoholism treatment units, therefore, were seen to have provided care to persons in the youngest age group.

Whereas the percentage of all federally-funded alcohol treatment units which cared for AI/ANs was 30.9 percent, the corresponding percentage for those treating persons age 18 annd younger was 38.0 percent and for units treating persons age 19 through 20 it was 36.1 percent. The percentage of alcohol and drug abuse treatment units which had had AI/ANs remained close to the overall percentage of 22.3 regardless of client age*.

Table 14

This table provides the same information as Table 13 but is restricted to treatment units which were in United States counties with American Indian reservations. The NDATUS showed in 1982 that there were 452 alcoholism treatment units and 204 alcohol and drug abuse treatment units in United States counties with American Indian reservations. Federal funding* was reported for 278 (61.5 percent) of alcoholism treatment units and for 127 (62.3 percent) of alcohol and drug abuse units. American Indian or Alaskan clients were reported for 151 (54.7 percent) of federally-funded alcoholism treatment units and for 70 (58.3 percent) of federally-funded alcohol and drug abuse treatment units.

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*No information is specifically available in the NDATUS on clients cross-classified by age and ethnicity.

The number of federally-funded alcohol treatment units which provided care to clients age 18 and younger was 114 (41.3 percent); to clients age 19 through 20, 163 (59.1 percent); and to clients age 21 and older 272 (98.6 percent). The number of federally-funded alcohol and drug abuse treatment units which provided care to clients age 18 and younger was 63 (52.5 percent), age 19 through 20, 81 (67.5 percent); and age 21 and older, 118 (98.3 percent). The percentages of units providing care to members of the two younger age groups, therefore, are higher for alcohol and drug abuse treatment units.

Treatment units in United States counties with American Indian reservations, like treatment units overall, showed that more AI/ANs were treated by treatment units with clients in the younger age groups. In contrast to the total sample, however, treatment units in United States counties with American Indian reservations were more likely than not to have treated AI/ANs.

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*See discussion for Table 13 for a list of what has been included as federal funding.

Table 1

Number and Percent of All Deaths by Age and Race, United States, 1980

Age	American Indian/ Alaskan Native		All Other Races	
	Number	Percent	Number	Percent
1-4	584	8.4	53,129	2.7
5-9	55	0.8	5,020	0.3
10-14	62	0.9	5,552	0.3
15-19	279	4.0	20,454	1.0
20-24	365	5.3	27,929	1.4
25-34	622	9.0	49,618	2.5
35-44	642	9.3	57,776	2.9
45-54	740	10.7	132,417	6.7
55-64	929	13.4	291,255	14.7
65-74	1,112	16.1	465,509	23.5
75-84	932	13.5	516,325	26.0
85+	597	8.6	357,373	18.0
Total*	6,916		1,982,357	

*Excludes 7 American Indian and 561 other deaths for which age was unknown.

SOURCE: National Center for Health Statistics, 1980.

Table 2

Number and Percent of Deaths for Various Causes Among American Indians, United States, 1980

Cause	Number	Percent
Diseases of heart	1,494	21.58
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	770	11.12
Motor vehicle accidents	754	10.89
All other diseases	732	10.57
All other accidents and adverse effects	536	7.74
Chronic liver disease and cirrhosis	410	5.92
Cerebrovascular diseases	322	4.65
Symptoms, signs and ill-defined conditions	295	4.26
Pneumonia and influenza	257	3.71
Homicide and legal intervention	219	3.16
Diabetes mellitus	210	3.03
Certain conditions originating in the perinatal period	199	2.87
Suicide	181	2.61
Congenital anomalies	94	1.36
Residual of infectious and parasitic diseases	88	1.27
Nephritis, nephrotic syndrome, and nephrosis	87	1.26
Chronic obstructive pulmonary diseases and allied conditions	86	1.24
All other external causes	48	0.69
Atherosclerosis	46	0.66
Tuberculosis	36	0.52
Hypertension with or without renal disease	22	0.32
Other diseases of arteries, arterioles, and capillaries	19	0.27
Ulcer of stomach and duodenum	14	0.20
Complications of pregnancy, childbirth, and the puerperium	3	0.04
Syphilis	1	0.01
All causes	6,923	100.00

SOURCE: National Center for Health Statistics, 1980.

Table 3

Number and Percent of Deaths for Various Causes
Among American Non-Indians, United States, 1980

Cause	Number	Percent
Diseases of heart	759,591	38.31
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	415,739	20.97
Cerebrovascular diseases	169,903	8.57
All other diseases	141,299	7.13
Chronic obstructive pulmonary diseases and allied conditions	55,964	2.82
Pneumonia and influenza	54,362	2.74
Motor vehicle accidents	52,418	2.64
All other accidents and adverse effects	52,010	2.62
Diabetes mellitus	34,641	1.75
Chronic liver disease and cirrhosis	30,173	1.52
Atherosclerosis	29,403	1.48
Symptoms, signs and ill-defined conditions	28,513	1.44
Suicide	26,688	1.35
Homicide and legal intervention	24,059	1.21
Certain conditions originating in the perinatal period	22,667	1.14
Other diseases of arteries, arterioles, and capillaries	19,940	1.01
Nephritis, nephrotic syndrome, and nephrosis	16,666	0.84
Residual of infectious and parasitic diseases	15,068	0.76
Congenital anomalies	13,844	0.70
Hypertension with or without renal disease	7,805	0.39
Ulcer of stomach and duodenum	6,101	0.31
All other external causes	3,638	0.18
Tuberculosis	1,942	0.10
Complications of pregnancy, childbirth, and the puerperium	331	0.02
Syphilis	153	0.01
All causes	1,982,918	100.00

SOURCE: National Center for Health Statistics, 1980.

Table 4

Number of Deaths and Age-Specific Death Rates for All Causes of Death by Race, United States, 1980*

Age	American Indian/ Alaskan Native		All Other Races	
	Number	Rate	Number	Rate
1-4	584	391.9	53,129	328.0
5-9	55	37.6	5,020	30.3
10-14	62	39.8	5,552	30.7
15-19	279	164.1	20,454	97.4
20-24	365	245.0	27,929	132.0
25-34	622	268.4	49,618	134.7
35-44	642	419.0	57,776	226.8
45-54	740	675.3	132,417	583.6
55-64	926	1,175.7	291,255	1,347.1
65-74	1,112	2,309.8	465,509	2,997.6
75-84	932	4,482.1	516,325	6,700.3
85*	597	10,201.6	357,373	15,997.9

*Age-specific death rates per 100,000 population.

SOURCE: National Center for Health Statistics, 1980.

Table 5

Age-Adjusted Mortality Rates for
Selected Causes of Death by Race, United States, 1980*

Cause of Death	American Indian/ Alaskan Native	All Other Races
Motor vehicle accidents	56.5	23.4
All other accidents	45.4	25.8
All homicide	16.4	10.9
All suicide	12.8	11.8
All alcohol-related causes	54.4	15.5
All drug-related causes	1.5	2.2

*Age-adjusted mortality rates per 100,000 population.

Table 6

Number of Deaths, Age-Specific Mortality Rates, and Proportionate Mortality Ratios (PMRs) for Deaths Caused by Motor Vehicle Accidents by Race, United States, 1980*

Age Group	American Indian/ Alaskan Native			All Other Races		
	Number	Rate	PMR**	Number	Rate	PMR
1-4	31	20.8	5.3	1,395	8.6	2.6
5-9	17	11.6	30.9	1,259	7.6	25.1
10-14	19	12.2	30.6	1,452	8.0	26.2
15-19	132	77.6	47.3	8,968	42.7	43.8
20-24	138	92.6	37.8	9,802	46.3	35.1
25-34	184	79.4	29.6	10,601	28.8	21.4
35-44	92	60.0	14.3	5,256	20.6	9.1
45-54	59	53.8	8.0	4,176	18.4	3.2
55-64	43	54.6	4.6	3,744	17.3	1.3
65-74	20	41.5	1.8	2,971	19.1	0.6
75-84	14	67.3	1.5	2,154	28.0	0.4
85+	5	85.4	0.8	614	27.5	0.2
All ages***	754	53.2	10.9	52,418	23.3	2.6

*Age-specific mortality rates per 100,000 population.

**PMR indicates for each age/race category the percent of all deaths that this particular cause of death represents.

***Includes 26 "Other Races" deaths for which age was not known.

SOURCE: National Center for Health Statistics, 1980.

Table 7

Number of Deaths, Age-Specific Mortality Rates, and Proportionate Mortality Ratios (PMRs) for Deaths Caused by Accidents Other Than Motor Vehicle Accidents by Race, United States, 1980*

Age Group	American Indian/ Alaskan Native Number	Rate	PMR**	All Other Races Number	Rate	PMR
1-4	43	28.9	7.4	3,010	18.6	8.7
5-9	20	13.7	36.4	1,144	6.9	22.8
10-14	17	10.9	27.4	1,295	7.2	23.3
15-19	53	30.6	18.6	3,107	14.8	15.2
20-24	61	40.9	16.7	3,946	18.6	14.1
25-34	99	42.7	15.9	6,277	17.0	12.7
35-44	84	54.8	13.1	4,129	16.2	7.1
45-54	48	43.8	6.5	4,604	20.3	3.8
55-64	48	57.1	4.9	5,421	25.1	1.9
65-74	37	76.9	3.3	5,969	38.4	1.3
75-84	18	86.6	1.9	7,109	92.3	1.4
85+	11	188.0	1.8	5,922	265.1	1.7
All ages***	536	37.8	7.7	52,010	23.1	2.6

*Age-specific mortality rates per 100,000 population.

**PMR indicates for each age/race category the percent of all deaths that this particular cause of death represents.

***Includes 1 American Indian and 76 other deaths for which age was not known.

SOURCE: National Center for Health Statistics, 1980.

Table 8

Number of Deaths, Age-Specific Mortality Rates, and Proportionate Mortality Ratios (PMRs) for Deaths Caused by Homicide or Legal Intervention by Race, United States, 1980*

Age Group	American Indian/ Alaskan Native			All Other Races		
—	Number	Rate	PMR**	Number	Rate	PMR
1-4	4	2.7	0.7	525	3.2	1.0
5-9	1	0.7	1.8	152	0.9	4.6
10-14	4	2.6	6.5	258	1.4	10.9
15-19	17	10.0	6.1	2,236	10.7	10.9
20-24	53	35.6	14.5	4,341	20.5	15.5
25-34	67	28.9	10.8	7,200	19.5	14.5
35-44	35	22.8	5.5	3,834	15.0	6.6
45-54	24	21.9	3.2	2,506	11.0	1.9
55-64	7	8.9	0.8	1,520	7.0	0.5
65-74	2	4.2	0.2	893	5.8	0.2
75-84	1	4.8	0.1	404	5.2	0.1
85+	1	17.1	0.2	117	5.2	0.0
All ages***	219	15.4	3.2	24,059	10.7	1.2

*Age-specific mortality rates per 100,000 population.

**PMR indicates for each age/race category the percent of all deaths that this particular cause of death represents.

***Includes 3 American Indian and 73 other deaths for which age was not known.

SOURCE: National Center for Health Statistics, 1980.

Table 9

Number of Deaths, Age-Specific Mortality Rates, and Proportionate Mortality Ratios (PMRs) for Deaths Caused by Suicide by Race, United States, 1980*

Age Group	American Indian/ Alaskan Native			All Other Races		
	Number	Rate	PMR**	Number	Rate	PMR
1-4	0	0.0	0.0	0	0.0	0.0
5-9	0	0.0	0.0	3	0.0	0.1
10-14	0	0.0	0.0	139	0.8	2.5
15-19	37	21.8	13.3	1,760	8.4	8.6
20-24	44	29.5	12.1	3,398	16.1	12.2
25-34	55	23.7	8.8	5,865	15.9	11.8
35-44	25	16.3	3.9	3,910	15.3	6.8
45-54	12	11.0	1.6	3,611	15.9	2.7
55-64	6	7.6	0.6	3,450	16.0	1.2
65-74	1	2.1	0.1	2,629	19.2	0.3
75-84	1	4.8	0.1	1,476	16.9	0.6
85+	0	0.0	0.0	430	19.2	0.1
All ages***	181	12.8	2.6	26,688	11.9	1.3

*Age-specific mortality rates per 100,000 population.

**PMR indicates for each age/race category the percent of all deaths that this particular cause of death represents.

***Includes 17 additional "Other Race" deaths for which age was not known.

SOURCE: National Center for Health Statistics, 1980.

Table 10

Number of Deaths, Age-Specific Mortality Rates, and Proportionate Mortality Ratios (PMRs) for Deaths Attributed to Alcohol-Related Causes by Race, United States, 1980*

Age Group	American Indian/ Alaskan Native Number	Rate	PMR**	All Other Races Number	Rate	PMR
1-4	1	0.7	0.2	46	0.3	0.1
5-9	0	0.0	0.0	8	0.0	0.2
10-14	1	0.6	1.6	9	0.0	0.2
15-19	7	4.1	2.5	78	0.4	0.4
20-24	10	6.7	2.7	199	0.9	0.7
25-34	94	40.6	15.1	1,709	4.6	3.4
35-44	159	103.8	24.8	4,412	17.3	7.6
45-54	149	136.0	20.1	8,773	38.7	6.6
55-64	89	113.0	9.6	10,841	50.1	3.7
65-74	53	110.1	4.8	7,707	49.6	1.7
75-84	17	81.8	1.8	2,601	33.8	0.5
85+	1	.17.1	0.2	486	21.8	0.1
All ages***	582	41.0	8.4	36,891	16.4	1.9

*Age-specific mortality rates per 100,000 population.

**PMR indicates for each age/race category the percent of all deaths that this particular cause of death represents.

***Includes 1 additional American Indian and 22 other deaths for which age was not known.

SOURCE: National Center for Health Statistics, 1980.

Table 11

Number of Deaths, Age-Specific Mortality Rates, and Proportionate Mortality Ratios (PMRs) for Deaths Attributed to Drug-Related Causes by Race, United States, 1980*

Age Group	American Indian/ Alaskan Native Number	Rate	PMR**	All Other Races Number	Rate	PMR
1-4	1	0.7	0.2	23	0.1	0.0
5-9	0	0.0	0.0	5	0.0	0.1
10-14	0	0.0	0.0	9	0.0	0.2
15-19	6	3.5	2.2	208	1.0	1.0
20-24	2	1.3	0.5	700	3.3	2.5
25-34	9	3.9	1.4	1,872	5.1	3.8
35-44	5	3.3	0.8	1,044	4.1	1.8
45-54	2	1.8	0.3	734	3.2	0.6
55-64	1	1.3	0.1	552	2.6	0.2
65-74	0	0.0	0.0	315	2.0	0.1
75-84	0	0.0	0.0	182	2.4	0.0
85+	0	0.0	0.0	43	0.5	0.0
All ages***	26	1.8	0.4	5,687	2.5	0.3

*Age-specific mortality rates per 100,000 population.

**PMR indicates for each age/race category the percent of all deaths that this particular cause of death represents.

***Includes 2 additional "Other Races" for which age was not known.

SOURCE: National Center for Health Statistics, 1980.

Table 12

Numbers and Percents of Clients Admitted to Federally-Funded Alcohol or Drug Treatment, by Age of Admission and Race, United States, January-December, 1981

Age Group	American Indian/ Alaskan Native		All Other Races	
	Number	Percent	Number	Percent
18 or younger	600	26.5	29,091	11.8
18-19	261	11.5	17,454	7.1
20-24	459	20.2	51,188	20.7
25 or older	947	41.8	149,500	60.5
Total	2,267		247,233	
Rate per 100,000 population		159.9		109.8

Source: National Institute on Drug Abuse, CODAP, 1981

Table 13

Number and Percent of Alcoholism and Alcohol and Drug Abuse Treatment Units Receiving Federal Funds with American Indians or Alaskan Natives in Treatment and Those with No American Indians or Alaskan Natives in Treatment,* by Client Age**
United States, September 30, 1982

Client Age	Treatment Orientation							
	Alcoholism				Alcohol and Drug Abuse			
	Units with American Indians or Alaskan Natives in Treatment		Units with No American Indians or Alaskan Natives in Treatment		Units with American Indians or Alaskan Natives in Treatment		Units with No American Indians or Alaskan Natives in Treatment	
	N	Percent	N	Percent	N	Percent	N	Percent
	N = 1,454				N = 861			
18 and Younger	211	38.0	345	62.0	112	24.0	356	76.0
19 through 20	305	36.0	541	64.0	136	25.1	405	74.9
21 and Older	436	30.5	993	69.5	181	22.0	640	78.0

* There were 21 alcoholism treatment units and 31 alcohol and drug abuse treatment units which did not report the race of their clients.

** Treatment units are listed for more than one age group. The unit is counted for each age group if 1 or more person whose age fell within the age group was in treatment. The number of treatment units with clients of various ages is compared to the number of treatment units with or without American Indians or Alaskan Natives in treatment. No information is specifically available on the number of units which treated American Indian or Alaskan Native juveniles on September 30, 1982. Within treatment orientation/age clusters, percents add to 100.

SOURCE: NATIONAL DRUG AND ALCOHOLISM TREATMENT UTILIZATION SURVEY (NDATUS)--1982.

Table 14

Number and Percent of Alcoholism and Alcohol and Drug Abuse Treatment Units Receiving Federal Funds with Indians or Alaskan Natives in Treatment and Those with No American Indians or Alaskan Natives in Treatment, by Client Age*, United States Counties with American Indian Reservations, September 30, 1982

Client Age	Treatment Orientation							
	Alcoholism				Alcohol and Drug Abuse			
	Units with American Indians or Alaskan Natives in Treatment		Units with No American Indians or Alaskan Natives in Treatment		Units with American Indians or Alaskan Natives in Treatment		Units with No American Indians or Alaskan Natives in Treatment	
	N	Percent	N	Percent	N	Percent	N	Percent
	N = 276				N = 120			
18 and Younger	72	63.2	42	36.8	44	69.8	19	30.2
19 through 20	97	59.5	66	40.5	55	67.9	26	32.1
21 and Older	148	54.4	124	45.6	69	58.5	49	41.5

* Treatment units are listed for more than one age group. All treatment units for United States counties with American Indian Reservations provided information on age. The number of treatment units with clients of various ages is compared to the number of treatment units with or without American Indians or Alaskan Natives in treatment. No information is specifically available on the number of units which treated American Indian or Alaskan Native juveniles on September 30, 1982. Within treatment orientation/age clusters, percents add to 100.

SOURCE: NATIONAL DRUG AND ALCOHOLISM TREATMENT UTILIZATION SURVEY (NDATUS)--1982.

Statement of
Congressman Bill Richardson
Indian Juvenile Alcoholism Hearing
October 24, 1985

Mr. Chairman, I commend you for taking the time to focus attention on this most critical problem. I am proud to be a cosponsor of H.R. 1156. I do not think there is any question that alcoholism and drug abuse on Indian reservations is one of the severest problems the Indian people have today. This problem impacts most severly on our Indian young people. These are people who will constitute the future of our Indian tribes. The lives of our Indian young people and the future of Indian tribes will continue to be unacceptably impaired unless the United States shoulders its responsibility and seriously addresses this problem.

Mr. Chairman, as you will recall, back in June, I had the opportunity to Chair field hearings in Albuquerque and in Phoenix on enacting an Indian Juvenile Alcoholism bill into law and discussing ways to ensure that the comprehensive approach agreed upon is effectively implemented by the Administration.

From our examination in New Mexico, it is evident that Indian young people represent an understudied and underreported population which warrants much more attention and study. In my home state of New Mexico, Indian Health Service Officials suspect that Indian youths are beginning to use alcohol as early as ages 10 to 13. Data collected by New Mexico area tribal contracted programs indicates that adults who are in treatment reported beginning to use alcohol at this early age. A large portion of the mental health workload in New Mexico Indian Health Service facilities is linked directly to alcohol related problems and stresses undergone by families and youth.

The evidence is clear that a grave problem exists. A plan of preventive action is needed now to address the problem at an early age and to promote healthy life styles and alcohol education. There is some effort being made by BIA schools -- but not enough is being done. For instance, I am told that in Chinle Arizona on the Navajo Reservation, BIA schools have a three-day a year alcohol prevention program. Three days a year are not enough.

A new approach to the very serious probelm of alcohol and drug abuse among our Indian young people from a perspective of prevention rather than after-the-fact treatment is urgently needed. The legislation under consideration today contains several good ideas in implementing ways to:

APPENDIX II

TUESDAY, APRIL 29, 1986

Additional Material Submitted for the Hearing Record

PREPARED STATEMENT OF TERRY KITCHEYAN

TESTIMONY ON H.R. 1156

INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT

We represent the Arizona tribes and are here to testify on behalf of the nineteen tribes and communities: Ak-Chin Indian Community, Camp Verde Yavapai-Apache Indian Community, Cocopah Tribe, Colorado River Indian Tribes, Ft. McDowell Indian Community, Ft. Mojave Tribe, Gila River Indian Community, Havasupai Tribe, Hopi Tribe, Hualapai Tribe, Kaibab-Paiute Tribe, Papago Tribe, Pascua Yaqui Tribe, Quechan Tribe, Salt River Pima-Maricopa Indian Community, San Carlos Apache Tribe, Tonto Apache Tribe at Payson, White Mountain Apache Tribe and Yavapai-Prescott Indian Community.

The State of Arizona contains 20 Indian reservations, the 19 previously named and the Navajo Nation with reservation lands totalling approximately 20 million acres which represent about 27 percent of the land base of Arizona. Arizona reservation population is approximately 167,000 persons of which 46 percent are 16 years of age and younger. Arizona reservations account for 40 percent of the national Indian reservation population and approximately 46 percent of the total reservation land base.

Arizona tribal leadership are concerned about the well-being of their young people. Through the integration of several resources, tribes are developing programs to meet the needs of their tribal youth. The Indian Juvenile Alcohol and Drug Abuse Prevention Act if passed with the recommended changes would expand and coordinate existing alcohol and drug prevention services for juveniles.

Arizona tribal leadership support the intent of the proposed legislation and raise several issues to strengthen its provisions and implementation.

TITLE I - COORDINATION:

Title I of the Act requires Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA) to enter into agreements to coordinate drug and alcohol abuse programs. The agreements would identify available resources for Indian people define the roles of each organizational agency and unit within IHS and BIA in coordinating services and determine the extent of drug and alcohol problems among Indian children. The agreements would be reviewed every six months. Tribes are to be consulted in the development of the agreements and may also request agreements be made at the local level that will include definition of referral systems.

COMMENTS:

Section 101 (a) (3). The responsibilities of BIA and IHS in coordinating alcohol and drug abuse need to be outlined, but no funds for this effort is provided by new appropriations. How will the work be funded through current budgets?

Section 102 (b) (2). Modifying the agreements between IHS and BIA semiannually does not seem to be realistic and would be costly. This should be changed to "be modified bi-annually..."

TITLE II - EDUCATION:

Title II requires that counselors working in programs funded by the Indian Elementary and Secondary School Assistance Act receive training in substance abuse counseling and that 10 percent of the fellowships awarded under the Indian Education Act be given to people who specialize in substance abuse guidance counseling. The Adult Education Act would also be amended to include provision of substance abuse counseling.

Substance abuse education in grades K - 12 at BIA and contracted schools is mandated by Title II. Some BIA schools would be required to remain open during summer months to provide recreation and counseling services for Indian children. BIA is also mandated to publish a quarterly newsletter about the programs funded under the Act.

COMMENTS:

Substance abuse education in grades K - 12 should be a priority activity, including the development of appropriate instructional materials. The publication and dissemination of a newsletter should be funded by alternate resources. Sections 204 and 205 should be changed to include, "services developed under this section shall be coordinated with existing local programs."

TITLE III - FAMILY AND SOCIAL SERVICES:

Title III of the Act concerns training for service providers. Community Health Representatives would be required to receive one week of substance abuse training. IHS would be mandated to provide training in substance abuse including crisis intervention and family relations to BIA and IHS personnel, to school boards, parent advisory committees, child protection teams and others upon request.

COMMENTS:

Section 301. It is our understanding that community health representatives and other IHS personnel already have alcoholism training available. Further, we understand that IHS and BIA have existing training dollars which can be utilized by IHS and BIA staff. Training for adults should be targeted for those persons identified in 301 (b) (2) and should be on-going local reservation based training. The benefits of training for BIA and IHS staff and other adults should not be a priority over direct services and preventive education for juveniles. We suggest the language at 301 (b) (1) be changed to read "The Director of the Indian Health Service may provide training...." Section 301 (b) (2) should include employees of tribal programs in the human services.

TITLE IV - LAW ENFORCEMENT:

Under Title IV of the legislation, BIA police would be trained on the substance abuse problems of Indian children. Tribal ,BIA and, Federal Law enforcement personnel would be required to detain children who are arrested for alcohol or drug offenses in shelter facilities, foster homes or community treatment facilities. State law enforcement personnel in P.L. 83-280 states would be "urged" to comply with this mandate. Shelter homes would be paid by the BIA and approved by the tribes.

COMMENTS:

Section 402 (a) (1). One problem with this section is that some tribes have juvenile codes which establish the procedures for handing juveniles arrested for alcohol and drug offenses. Those often include release to parents. The proposed legislation is too restrictive in that it requires shelter placement, and would seem to supercede tribal codes and parental involvement. The other concern is that shelter placement may not be the best option for a youngster involved in serious drug trafficking or for one who is violent. We recommend the language at 402 (a) (1) line 6 be changed to read "... drugs or alchol shall, when appropriate, detain such juvenile in a temporary emergency center...."

TITLE V - TREATMENT AND REHABILITATION OF CHILDREN:

The Director of IHS is mandated under Title V to research the need for, the cost of and the appropriate location of substance abuse residential treatment facilities for Indian children. IHS hospitals would be required to provide comprehensive alcohol and drug services, including detoxification and counseling, and IHS would have authority to build regional substance abuse treatment centers for youths.

COMMENTS:

Section 502. No funds are authorized for this Title. The IHS alcoholism services are currently under-funded. What mechanism will be used to assure comprehensive alcohol and drug treatment facilities and the construction of new facilities when no new funding is available?

TITLE VI - DEFINITIONS, EFFECTIVE DATE, AND AUTHORIZATION OF APPROPRIATIONS:

Title VI provides definitions to terms used in the proposed legislation and authorizes an appropriations of $5,000.000.

COMMENTS:

Section 603. We do not believe that $5,000.000 is a large enough sum to carry out all of the work specified by Title II, III and IV. We recommend that $30,000,00 be authorized to carry all the provisions in all title of the legislation.

Testimony of Rhoda Tso, Spokesperson
Page High School
Page, Arizona

Attending UNITED NATIONAL INDIAN TRIBAL YOUTH CONFERENCE, Washington, D.C.

COMMENTS

on H.R.1156 "Indian Juvenile Alcohol and Drug Abuse Prevention Act"

Mr. Chairman, Members of the Committee:

On behalf of the Navajo students at Page High School and as members of the Page High School Intercultural Club, we would like to take this opportunity to thank you for allowing us to express our concerns toward H.R. 1156, "Indian Youth Alcohol and Drug Abuse Prevention Act."

In our testimony, we will clarify our situation regarding alcohol and drug abuse among Native Americans in our area, and the views we have of the bill itself.

Page High School is basically made up of two ethnic/racial groups, Anglo and Navajo; each approximately fifty percent of the slightly more than eight hundred student body total.

In order to get a general idea of the status of students in our area, we took a poll among 103 Senior students. We found that of the 63 Native Americans we polled, 41 percent said they do use alcohol. 16 percent admit to having abused alcohol at one time or another. Of the same group, 24 percent claim to use drugs; 14 percent said they have abused drugs.

In our poll, we asked all 103 students (mixed group) how they would rate the alcohol and drug problem at Page High School on a scale of one to five (five being the most severe). The alcohol problem averaged the rating of 3.0 while the drug problem rated slightly lower with the average of 2.6.

Finally, we asked students when they had first experimented with drugs or alcohol. Excluding those who've never tried them, Native Americans averaged 14.8 years old as the first time they drank alcohol; with drugs, they averaged 15.2 years of age. According to the poll, some students tried alcohol and drugs as early as seven or eight years of age.

From the information we gathered, we can conclude that our area has been stung by this epidemic similar to the pattern of the rest of the Native Americans. It is sad to know that many of our Indians are already trapped within the cycle they want so desperately to escape.

We agree that if we are to overcome this frightening situation, we must treat alcohol and drug abuse like any other serious disease. The same principles can be applied. First, we must treat those who are very ill. Next, we must stop those who are in present danger. Third, and most important, we must educate the coming generation. If students are starting to experiment at age seven, programs taught by well-trained persons need to start early when they are in preschool and in kindergarten. We are especially pleased to see that you have included such programs in this bill.

We all realize alcohol and drug abuse is a problem that needs to be dealt with; however, we need to be concerned with problems that have resulted from these abuses as well. The problem we have in mind is suicide. Suicide is the second leading cause of death among Native Americans. Alcohol plays a factor in 75 to 80 percent of them. We feel that this bill could be improved by adding programs to help prevent more Indians from taking their lives. We hope the discussion of this bill in Washington will give us some concrete suggestions addressing this need.

Miss Rhoda Tso, Spokesperson
Page High School, Page, AZ

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RELEVENT INFORMATION

Before we felt we could make any statement upon receipt of this information and copy of Bill 1156, (April 12th) we wanted to know what the local situation was and what was being done already so selected persons ran the above mentioned poll of 103 Seniors.

Miss Tso interviewed our Assistant Principal and Counselors about the Y.A.A.P. program and the trend seen over the last few years. She also interviewed our local Social Services representative(s) for further data about the Social Service organizations attacking this problem and giving family assistance available in our area; and checked what the law enforcement services are providing.

Information was gathered as to what the youth services division of the Navajo Tribe offers in way of programs, facilities and involvement offering sports, activities and programs for all ages of youth throughout the year and especially as summer programs.

CONCLUSIONS:

1. There are many avenues already attacking this national problem. THEREFORE the Bill 1156 is correct in COORDINATING AND EXPANDING SERVICES but should not add another administrative level

(and its expenses) through these funds. Through this bill, guidance and publicity (through the proposed newsletter) can be shared as to what is available or will be available and providing an avenue for sharing pertinent information on a national basis.

2. We support the expenditures for training adults and also SUGGEST MORE PEER counselors for every age level and support the improvment of family services as needed. INDIVIDUAL contact and support seems very pertinant to the success of rehabilitation work, prevention programs and motivational programs.

3. Parental involvement is to be encouraged and we have only begun to identify this area. As economic levels improve, as intercultural understandings are cultivated, parents can take a more active position in communications with their children and improve their understanding of the world the children face, encourage educational motivation of their children and interact more affecitvely with their children in chosing good alternative behaviors from the many avenues bombarding young people today, thus giving more value clarification and encouragement of more critical selectivity on children's part.

4. "Masculinity", "femininity" and "family" concepts need clarification, cultivation and appreciation from adults and children in order to engender a mutual support system and improve our future. The greatness of this nation has always been evident in the growth of social, physical,mental and SPIRITUAL commitment of our people. The elevation of manhood and womanhood and reaffirmation of the importance of a strong non-denominational spiritual commitment on the part of individuals will do much to offset the extremely materialistic trends

seen today.

Washington delegation approving this paper:

Miss Deborah Saliego, Club President
Miss Marietta Yazzie
Mr. Steven E. Begay
Mr. Russell Secody
Miss April Grayeyes
Miss Josephine Worker
Miss Josephine Bia
Miss Rhoda Tso
Miss Vanessa VanWinkle
Mr. Lucas Sandoval
Mr. Rodney Slim
Miss Michelle Etcitty
Mrs. Mary L. Blake, Club Sponsor

TESTIMONY BEFORE THE HOUSE INTERIOR AND INSULAR AFFAIRS COMMITTEE ON H. R. 1156

THE INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT

PRESENTED BY THE HONORABLE DOUG BEREUTER

APRIL 29,1986

MR.CHAIRMAN AND INTERIOR COMMITTEE COLLEAGUES, GOOD MORNING. ONCE AGAIN, IT IS A PLEASURE TO BE WITH YOU TO DISCUSS AN IMPORTANT MATTER THAT HAS OCCUPIED A GREAT DEAL OF MY TIME AND ATTENTION THESE PAST THREE YEARS. WHEN MY COLLEAGUE FROM SOUTH DAKOTA, TOM DASCHLE, AND I APPEARED BEFORE THIS COMMITTEE IN APRIL OF 1984, WE ASKED YOU TO ADD FOUR ALCOHOL AND DRUG ABUSE PREVENTION AMENDMENTS TO THE INDIAN HEALTH CARE IMPROVEMENT ACT THAT WOULD FORM THE BASIS OF OUR LARGER EFFORT, WHICH WE ARE CONSIDERING HERE THIS MORNING. AS WE ALL KNOW, THE INDIAN HEALTH CARE IMPROVEMENT ACT WILL BE VOTED ON TODAY, AND I FULLY EXPECT THAT IT WILL PASS. IT THUS SEEMS FITTING THAT TODAY WE CONCLUDE THE HEARINGS ON THE INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT, H.R. 1156, AS WE APPROVE THE INITIAL WORK THAT WILL ALLOW FOR SOME IMMEDIATE TRAINING OF TEACHERS AND COUNSELORS IN THE VERY CRITICAL AREA OF ALCOHOL AND DRUG ABUSE PREVENTION.

WHAT IS EVEN MORE FITTING, HOWEVER, IS THAT TODAY WE WILL FINALLY HEAR FROM THOSE INDIVIDUALS WHO REPRESENT THE GROUP THAT WILL MOST BENEFIT BY THE PASSAGE OF THIS LEGISLATION. I AM HONORED AND PLEASED TO WELCOME YOU PARTICIPANTS IN THE UNITY CONFERENCE TO WASHINGTON, AND TO THIS HEARING. I COMMEND YOU FOR THE WORK THAT YOU ARE DOING, AND FOR YOUR INVOLVEMENT IN THE POLITICAL PROCESS, FOR CERTAINLY THAT IS ONE AREA WHERE INFORMED PARTICIPATION CAN MAKE A VERY REAL DIFFERENCE. AS YOUNG LEADERS, YOU ARE THE PLANNERS FOR THE FUTURE AND THE SPOKESPERSONS FOR THE PRESENT. YOUR SPOKEN VIEWS AND SHARED OBSERVATIONS ARE KEENER AND MORE INSIGHTFUL THAN ANY WRITTEN REPORTS CAN CONVEY. YOUR INFLUENCE AMONG YOUR PEERS PUTS YOU ALL IN A POSITION OF GREAT RESPONSIBILITY. I HOPE THAT YOU WILL BEAR THE NEWS HOME, TO YOUR INDIVIDUAL RSERVATIONS AND COMMUNITIES, THAT CONGRESS IS AWARE OF YOUR STRUGGLE TO IMPROVE THE LIVES OF YOUR PEOPLE, AND INTENDS TO HELP IN PART OF THAT STRUGGLE BY ASSISTING INDIAN PEOPLE IN PROVIDING ALCOHOL AND DRUG ABUSE PREVENTION PROGRAMS IN SCHOOLS AND BY PROVIDING A FRAMEWORK FOR INCREASED COMMUNITY PARTICIPATION IN THAT EFFORT.

WE DO KNOW THAT ALCOHOL AND DRUG ABUSE IS THE NUMBER ONE HEALTH AND SOCIAL PROBLEM ON THE RESERVATION TODAY. SOME RESERVATIONS HAVE TOLD US THAT AS MUCH AS 77% OF THEIR HEALTH CARE BUDGETS ARE USED FOR ALCOHOL AND DRUG RELATED SERVICES. WE HAVE BEEN TOLD THAT ON SOME RESERVATIONS ALCOHOL AND DRUGS ARE A FACTOR IN 90 % OF THE

ACCIDENTS THAT OCCUR. OF COURSE, ALCOHOL AND DRUG ABUSE IS A PERVASIVE PROBLEM IN AMERICAN SOCIETY AT LARGE, BUT WHEN IT DEVASTATES LIMITED TRIBAL HEALTH CARE BUDGETS AND PLAYS A ROLE IN ACCIDENTS AND DEATH TO THE EXTENT THAT IT DOES, IT WARRANTS SPECIAL ATTENTION AND A SPECIAL EFFORT.

ONCE AGAIN, THEN, WELCOME. LET ME SAY THAT I HAVE ANTICIPATED THIS PARTICULAR HEARING WITH MUCH PLEASURE, AND I LOOK FORWARD TO YOUR COMMENTS AS WELL AS AN OPPORTUNITY TO ASK YOU QUESTIONS.

THE STATEMENT OF STEPHANIE N. FOX, FROM THE DAKOTA REGION CONCERNING H.R. 1156 BEFORE THE COMMITTEE ON INTERIOR AND INSULAR AFFAIRS ON APRIL 29, 1986.

Dear Mr. Chairman and members of the Committee:

My name is Stephanie N. Fox, student at Mandaree Public School, Mandaree, North Dakota. Mandaree High School is located on the Fort Berthold Indian Reservation. The Three Affiliated Tribes, Mandan, Hidatsa, and Arikara Indians live on this reservation.

I am from one of the ten tribes of the Dakota Region. There are six Indian reservations located in the state of South Dakota and four Indian reservations in the state of North Dakota.

The Indian youth on or near these ten Indian reservations need alcohol and drug related programs. I am very glad and happy that this committee is having public hearings on H.R. 1156. After having studied H.R. 1156 I believe that it is needed. The Bill is a good starting place to begin meeting the needs of the Indian Youth who have problems with alcohol and drugs.

I like the provisions under Title II Education and Title V Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation of the Bill.

In title II. Education, it provides for training of counselors in counseling techniques relevant to alcohol and drug abuse. The School Counselor makes the most contacts of students who have alcohol and drug problems. If the counselors have this training they will make the most impact on the Indian youth who are having alcohol and drug problems. As a rule in most of the schools located in the Dakota region the counselor/student ratio is much higher in favor of the students. This high ratio makes it clear that the counselors need this training so that their time with the Indian Youth is spent efficiently.

Another feature that I like under Title II is that the schools that are located on these Indian reservations can be used during non-academic time to provide alternative activities to using alcohol and drugs. This will ensure the establishment of summer recreation and counseling programs. The summer months is the time when much alcohol and drug problems exist on these ten Indian reservations. If the schools on or near these Indian reservations are open in the summer to provide recreational activities and counseling to Indian Youth it would greatly reduce the alcohol and drug problems.

The other title that I would like to make some comment on is Title V of the Bill. I support the conduct of the study that is required of the Indian Health Services under Section 501. We all know that there are alcohol and drug problems with Indian Youth but there are very few studies conducted. The alcohol program under our Tribal Council is having a time trying to deal with the three items under this section. This study will help our Tribal Council by providing a copy of the report to them. I am sure other tribes wuld like to see the results of this study.

The Director of IHS must provide a comprehensive alcohol and drug abuse treatment services, including detoxification and counseling services, and follow-up care in Indian Health Service facilities, and in facilities operated under contract under Pub. L. 93-638 to Indian juveniles and adults in need of such services. I feel that with the provisions under Title II and Title V will start to help the Indian Youth who have alcohol and drug problems.

I urge the Chairman and the Committee Members of the Interior and Insular Affairs to work towards making H.R. 1156 a law to help the Indian Youth and adults who have alcohol and drug abuse problems.

I thank the Chairman and the Committee Members for the opportunity to testify on H.R. 1156.

STEPHANIE N. FOX
STUDENT MANDAREE
PUBLIC HIGH SCHOOL
MANDAREE, ND 58757

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Ladies and Gentlemen:

We, the representatives of the Wind River Indian Reservation Youth Council, wholly support the intent of H.R. 1156 "Indian Juvenile Alcohol and Drug Abuse Prevention Act."

The suicide epidemic occurring on our reservation, Wind River Indian Reservation, WY, began in August, 1985 and claimed twelve young lives; alcohol and drugs were misused in some of the incidents. Specific to most reservations are environmental factors that contribute to abuse of alcohol and drugs. Some of these factors are the breakdown of tribal tradition, lack of effective Indian adult role models, alcoholic parents, broken homes, unemployment, early marriage and parenting, and school failure.

Some measures that we envision to reduce the rate of alcohol and drug abuse are:

Recreation: Facilities, funds, and parental involvement are needed. Additionally, the facilities can house educational materials for drug and alcohol abuse prevention, suicide prevention, and a help hotline using peer counselling.

Use of Tribal Elders: The tribal value system and traditional ways of coping with modern-day stress can be modelled.

Education: Because of the high incidence of alcohol and drug abuse among the reservation youth, the reservation school curriculum will include drug and alcohol abuse education at K-12 systems and Headstart programs.

Parental involvement: Community resources such as churches, parent groups, and local resource agencies can impact parenting skills, teenage pregnancy, effects of alcohol and drug abuse contributing to adverse home environmental factors.

We are in agreement with other tribes and organizations that another level of management is not necessary to deal with these many problems. The Bureau of Indian Affairs and the Indian Health Services should be able to identify available resources. The Community Health Representatives could be a primary outreach resource.

Thank you for giving us this opportunity to express our views on H.R. 1156.

Respectfully submitted,

Scott Murray, Lander Valley High School
Ann Ab[illegible]ta, Wyoming Indian High School

STATEMENT OF
CONGRESSMAN BILL RICHARDSON
INDIAN JUVENILE ALCOHOLISM HEARING
APRIL 29, 1986

I WANT TO WELCOME ALL OF YOU WHO HAVE TAKEN THE TIME TO SHARE YOUR VIEWS ON THIS MOST CRITICAL PROBLEM. I UNDERSTAND STUDENT WITNESSES ARE IN WASHINGTON FOR A NATIONAL INDIAN YOUTH CONFERENCE AND ARE DRAWN FROM CONFERENCE PARTICIPANTS FROM ARIZONA, NEW MEXICO, SOUTH DAKOTA, NORTH DAKOTA, NEBRASKA, WYOMING, MONTANA, OKLAHOMA, WISCONSIN, OREGON, UTAH AND MISSISSIPPI -- 12 DIFFERENT STATES. I APPRECIATE THE OPPORTUNITY TO BE ABLE TO BE A PART OF TODAY'S PROCEEDINGS AND HOPE THAT YOUR INPUT WILL SOUND THE CALL FOR ACTION BY THE HOUSE OF REPRESENTATIVES IN THE 99TH CONGRESS TO FAVORABLY ACT ON LEGISLATION DESIGNED TO CURB ALCOHOL AND DRUG ABUSE AMONG OUR YOUNG NATIVE AMERICANS.

I DO NOT THINK THAT THERE IS ANY QUESTION THAT ALCOHOLISM AND DRUG ABUSE ON INDIAN RESERVATIONS IS ONE OF THE SEVEREST PROBLEMS THE INDIAN PEOPLE HAVE TODAY. THIS PROBLEM IMPACTS MOST SEVERELY ON OUR INDIAN YOUNG PEOPLE. THE YOUTH OF TODAY WILL CONSTITUTE THE FUTURE LEADERS OF TOMMORROW. THE LIVES OF OUR INDIAN YOUNG PEOPLE AND THE FUTURE OF INDIAN TRIBES WILL CONTINUE TO BE UNACCEPTABLY IMPAIRED UNLESS WE SERIOUSLY ADDRESS THIS PROBLEM. I WANT TO GIVE MY ASSURANCES, AS A MEMBER OF THE HOUSE INTERIOR COMMITTEE AND A COSPONSOR OF H.R. 1156, THAT I AM SERIOUS ABOUT DOING ALL I CAN TO ENSURE THAT THIS LEGISLATION IS ENACTED INTO LAW AND SEEING THAT IT IS EFFECTIVELY IMPLEMENTED BY THE ADMINISTRATION.

I WANT TO COMMEND MY COLLEAGUE, THE HONORABLE TOM DASCHLE OF SOUTH DAKOTA FOR HIS LEADERSHIP ON THIS ISSUE AND MY COLLEAGE, THE HONORABLE JOHN MCCAIN OF ARIZONA FOR PRESENTING HIS OWN APPROACH TO COMBAT THIS PROBLEM. IT IS MY HOPE THAT WITH TWO BILLS BEING CONSIDERED THE CHANCES OF THE CONGRESS TAKING ACTION WILL INCREASE.

BACK IN JUNE OF 1985, I HAD THE OPPORTUNITY TO CHAIR TWO FIELD HEARINGS -- ONE IN ALBUQUERQUE, NEW MEXICO AND THE OTHER IN PHOENIX, ARIZONA -- ON THE INDIAN JUVENILE ALCOHOLISM BILLS.

FROM OUR EXAMINATION IN MY HOME STATE OF NEW MEXICO, IT IS EVIDENT THAT OUR INDIAN YOUNG PEOPLE REPRESENT AN UNDERSTUDIED AND UNDERREPORTED POPULATION WHICH WARRANTS MUCH MORE ATTENTION AND STUDY. IN NEW MEXICO, INDIAN HEALTH SERVICE OFFICIALS SUSPECT THAT INDIAN YOUTHS ARE BEGINNING TO USE ALCOHOL AS EARLY AS AGES 10 TO 13. DATA COLLECTED BY NEW MEXICO AREA TRIBAL CONTRACTED PROGRAMS INDICATES THAT ADULTS WHO ARE IN TREATMENT REPORTED BEGINNING TO USE ALCOHOL AT A VERY EARLY AGE. A LARGE PORTION OF THE MENTAL HEALTH WORKLOAD IN NEW MEXICO IHS FACILITIES CAN BE DIRECTLY LINKED TO ALCOHOL RELATED PROBLEMS AND STRESSES UNDERGONE BY FAMILIES AND LYOUTH.

THE EVIDENCE IS CLEAR THAT A GRAVE PROBLEM EXISTS. A PLAN OF PREVENTIVE ACTION IS NEEDED NOW TO ADDRESS THE PROBLEM AT AN EARLY AGE AND TO PROMOTE HEALTHY LIFE STYLES AND ALCOHOL EDUCATION. THERE IS SOME EFFORT BEING MADE BY BIA SCHOOLS -- BUT NOT ENOUGH IS BEING DONE. FOR INSTANCE, I WAS TOLD LAST FALL THAT IN CHINLE, ARIZONA ON THE NAVAJO RESERVATION, BIA SCHOOLS HAVE A THREE-DAY A YEAR ALCOHOL PREVENTION PROGRAM. THREE DAYS A YEAR ARE NOT ENOUGH.

A NEW APPROACH TO THE VERY SERIOUS PROBLEM OF ALCOHOL AND DRUG ABUSE AMONG OUR INDIAN YOUNG PEOPLE FROM A PERSPECTIVE OF PREVENTION RATHER THAN AFTER-THE-FACT TREATMENT IS URGENTLY NEEDED. THE LEGISLATION UNDER CONSIDERATION TODAY CONTAINS SEVERAL GOOD IDEAS IN IMPLEMENTING WAYS TO: WORK WITH FAMILIES; SCHOOLS; THE INDIAN HEALTH SERVICE; AND COORDINATING PREVENTION EFFORTS ALREADY OPERATING IN INDIAN COMMUNITIES.

I AM HERE TODAY TO LISTEN AND LEARN AND I CAN ASSURE YOU THAT I WILL CONTINUE TO DO ALL I CAN IN THE DAYS AHEAD TO PRESS AHEAD FOR AN EARLY MARK-UP AND PASSAGE OF EFFECTIVE LEGISLATION TO DEAL WITH THE SERIOUS PROBLEM OF INDIAN YOUTH ALCOHOLISM.

ALCOHOL AND DRUG USE AMONG INDIAN YOUTH
OBSERVATIONS, PROBLEMS, NEEDS AND CONCERNS

A paper presented to:

House Committee on Interior and Insular Affairs
Washington, D.C.
April 29, 1986

Mr. Lloyd Talas
Santa Fe Indian School
12th Grade High School student

My name is Lloyd Talas and I am a Hopi student attending the Santa Fe Indian School, which is located in the state of New Mexico. I am a senior this year and will be graduating on June 5, 1986. I have been a student at the Santa Fe Indian School for the past four years. I feel that the school has been a great asset to me and other students and it will continue to be for years to come. It has been an educational and learning experience for me, in helping me to cope and deal with different aspects of my life, which include alcohol and drug use and abuse among us students in school.

My personal and general observations of alcohol and drug use and abuse is that it affects everyone and not only the users and abusers. I have seen my own family, relatives, friends and others and how it has had an affect on them and their lives and at times where it was devastating. It causes destruction through death, accidents, violence, incarceration, breaking up of families, suicide or attempts at suicide and crime. Yet, you see alcohol and drug usage glamorized in newspaper, magazines, radio, television, billboard displays, posters, album covers, music, hard rock bands and many sources. Alcohol, marijuana, inhalants and other drugs are easily available and can be obtained just about anywhere you turn. You can get them from your own parents, brothers, sisters, relatives, peers, friends, bootleggers and even people you don't even know who will actually approach you.

One of the biggest obstacles, especially with alcohol, is that it is accepted by the general public and society as a whole. With alcohol and other drugs, it is okay to do as much advertising as one is allowed to and usually it is allowed to go overboard alot of the time. These are some of the things we see as young people.

Problems resulting from alcohol and drug use and abuse among Indian youth are phenomenal. In the school, and at home many young Indian people spend their money on alcohol and other durgs and have nothing to show for it, except hangovers, being arrested, being sent to the detention center, being sent to the corrections home, being written up for a substance abuse incident, having to appear before a tribal council/judge or probation officer, and involvement in accidents.

Negative attitudes and behavior are built and evident in young Indian people that are involved with alcohol and other drug use and abuse. In restrospect you see a lack of concentration and participation in school work and activities and the inability to complete assignments or tasks. Many Indian youth get into fights, arguments and other personal conflicts. They shut out other people who are willing and wanting to help and guide them in a positive way. Their personal hygiene is affected and this can be seen through their sloppy dress, lack of cleanliness. You see the lack of respect for themselves, elders, parents, staff and the law. Most important of all, they lack respect for their cultural and traditional way of their respective tribes. It causes disunity among our own people, both young and old. Other problems are a high rate of drop outs, being dismissed from school because of alcohol and drug use and abuse, absenteeism from classes, and discipline.

These are but a few problems mentioned that we, as young concerned people see as a result of alcohol and drug use and abuse among Indian youth in our area. To put it simply, alcohol and drug abuse is very damaging to the Indian youth, spiritually, mentally and physically. Many hopes, dreams and goals of individual Native Americans and tribes have not been achieved because of alcohol and drug abuse and the problems they bring. We, as Indian youth, must be assured that people working with us in this area or field are themselves emotionally stable.

The needs are many! There are programs in place, but many of them are geared toward working with adults. There have been occasions where young people were placed in these facilities (in-treatment, half-way homes) for treatment and could not relate to what was going on. They also felt uncomfortable because of the age difference. This is especially true with young Indian people that are referred to some of these facilities. We need facilities for young Indian people that are geared towards their rehabilitation using our own traditional and cultural awareness people. Together with other prevention, intervention and alcohol/drug education activities would give us more pride and self esteem. We need more involvement by all our Indian people to unite and work together in combating this problem.

We need more progams aimed at prevention and intervention. That is not to exclude treatment programs, both in-patient and out-patient. We need alot of family involvement during the treatment process and after the process. We need good community programs to work with our school programs to better serve the Indian youth. In school, we have alcohol/drug counseling education and are taught coping skills, life skills, but alot of time there is no follow-up from community based programs that students are referred to during the summer.

We need monies provided to schools to provide more community outreach. In law enforcement, there needs to be a study made in how they deal with public intoxication, DWI and other alcohol/drug related situations among Indian youth. We need stricter law for the selling of alcoholic beverages (checking ID's, setting the legal age limit for buying alcoholic beverages at twenty-one years old for all states, law enforcement agencies keeping a closer watch on possible bootleggers). Laws need to be amended to prohibit or censor certain information on alcohol and drug advertisements. The needs are endless.

Most important of all is to implement these programs and to work together on the needs expressed by all of us to combat alcohol and other drug use and abuse among Indian youth through prevention, identification, treatment and follow-up as proposed in H.R. 1156. I hope that our concerns and comments will seriously be considered in the final analysis and draft of H.R. 1156.

In conclusion, I would like to thank the committee for giving me the opportunity to present some personal and general observations in regards to problems resulting from alcohol and drug abuse among Indian youth and the needs for this growing problem. I would also like to thank the Santa Fe Indian School for giving me this opportunity to be here. May the Great Spirit bless you all.

PREPARED STATEMENT OF JILL CAREY

Mr. Chairman and members of the committee. My name is Jill Carey and I am a Cherokee Indian. I am 18 and am presently attending Sequoyah Indian High School, one of the 6 off reservation boarding schools in the nation. I merely wish to convey to you my own deep personal concerns with the problems that I see effecting my closest peers and friends.

There are approximately 125 students attending Sequoyah High School and out of that number at least 90% are frequent users of alchol and, or drugs, out of that number at least 50% have seriouse addiction problems. These are alarming and extremely serious ratios.

Before, I go any further, I would like to share a few facts with you. 116 years ago today the treaty of Fort Laramie was signed with the Sioux lands and their allies establishing the great Sioux reservation in South Dakota. The same reservation where today, 2 out 3 of their youth ages 12-18 are cronic alcoholics, and 2 out of 3 of all teenage girls under 17 become unwed mothers, giving birth to alcoholic infants. "In 1984 there were oore Indian children in government boarding schools than there were Cherokees on an forced march to Oklahoma as on the infamous and tragic Trail of Tears in the 1830's. Just 25 miles from Tahlequah, where I live in Adair County of Oklahoma, the tee teenage alcoholism and teenage pregnancy rates are higher per-capita than Harlem in New York City. Oklahoma is 10th in the nation for arrests connected with teenage drug and alcohol abuse.

The devistation and havic that this problem creates has touched all of us, not just those who are victims of its grip. But as our youth are torn away from that love of mother earth, it spawns corruption and de composition of all that we as human beings hold dear. I have no technical recommendations, all I have is support for anything that can intervene in the path that the future of our Indian Youth are on.

As a Christian, I know that the only way that these young people will survive, and rise above the ashes and ruble is with the help and up lifting of our Heavenly Father. But every amount of help and support and expression of genuine lave that we show these individuals will help the healing process. This bill will help give them the chance to become healthy, whole, productive citizens. We all deserve at least that chance.

PREPARED STATEMENT OF OSCAR SCHUYLER

Gentlemen:

I am Oscar Schuyler of the Oneida Tribe Of Indian. It's an honor for me to be here to represent the Oneida U.N.I.T.Y.

We feel that there is a Drug and Alcohol Abuse Problem among the Youth in our Community and in many other communities on Reservations. We feel that this problem is mainly caused by Youth trying to fit in, Peer Presures and Divorce and all the little problems added up to one BIG PROBLEM. I know one kid that drinks, doesn't touch Drugs, but drinks a lot. When he first started drinking his mothere said it was O.K. but then he started to drink too much and started to get into arguments with his mother all the time. Then he moved, to go live with his father. He did this back and forth for about a year. He finally decided to stay with his father. He stopped drinking for a long time. He then turned 19 and felt he could drink again, and hold it to a limit. He did until he started to get depressed and all his Problems came to haunt him and made him suicidal. His mother then came out for a funeral and to talk to him. We noticed that he went everywhere that day with her and got kind of attached to her again.

When she left he was O.K. for two weeks then he started having problems with his girlfriend and turned to Alcohol for relief, but it got worse, and once again he became suicidal. He tried Suicide 5 times in less than a month. The reason I know this person very well is because he's my brother. I feel that there is more people like this not only on the Reservation, but with Youth all over the world. I feel to help these problems we need something that the whole family can go to instead of just the troubled Youth. This should be a place with religion and where the families help out each other with the problems of their Youth.

We as Oneida Youth offer our support to H. R. 1156. This legislation can directly affect our future and the future of our loved ones.

The need for Qualified people to work with Indian Youth and families in the area of Alcohol and Drug Abuse at the community level can not be over emphasized. I think that the right way to run an Alcohol and Drug Abuse Programs is to have the responsibility in the hands of people who are either themselves recovered alcoholics or who have lived in an alcoholism plaqued family, and who are also willing to professionalize themselves.

I would like to Thank You once again for the opportunity to offer again this testimony and the needs of Indian Youth will not be ignored.

INDIAN JUVENILE ALCOHOL & DRUG ABUSE PREVENTION ACTION HR-1156

Testimony presented to

HOUSE COMMITTEE ON INTERIOR & INSULAR AFFAIRS

Submitted By:

Tony Stacona
Alvis Smith III
Stacey Leonard
Lisa Briseno

On Behalf Of

The Confederated Tribes of the
Warm Springs Reservation of Oregon

and

Madras Senior High School

Good Morning Mr. Chairman, Members, and Staff.

My name is Tony Stacona, with me today are Alvis Smith, Stacey Leonard, and Lisa Briseno. We are enrolled members of the Confederated Tribes of the Warm Springs Reservation of Oregon, and are currently enrolled in Madras Senior High School. We want to express our gratitude to the members of the House Committee on Interior and Insular Affairs, other esteemed members of Congress and UNITY for this opportunity to testify on the Indian Juvenile Alcohol and Drug Prevention Act, HR-1156. We also want to convey to you the appreciation of our fellow students, our people, our school, and our Tribal government for giving us this opportunity.

We are extremely proud to support the intent and purposes of HR-1156, it will address one of the several critical needs of Indian Youth -- our peers. We want to commend and thank Congressmen Bereuter, Daschle, Udall, Young of Alaska, Williams, and other sponsors for their sensitivity, foresight, and leadership in behalf of Indian Youth. Passage of this legislation will contribute greatly to the spirit and quality of the government to government cooperation necessary for the protection and advancement of Indian human resource interests.

Alcohol and drug abuse remains at epidemic proportions within most Indian communities, no family has been spared the agony and hurt that it causes. Substance use and abuse often fuels a vicious circle that entraps and controls many lives, it is an addictive escape that can become a way of life. We can see the effects all around us, the lack of hope, and feelings of powerlessness to bring about change or improvements. We are grateful to know that there are concerned people such as yourselves who are willing to help us and our community become all that we are capable of being or doing.

We have known that drugs and alcohol are a problem, we were not aware of the far-reaching impacts and costs. Our research and preparation for this testimony was enlightening. The information included these findings:

- Approximately 40% of Indian students may not complete high school with their class. Some may complete an equivalency program later.
- Among Tribal Members between the ages of 19 and 27, only 17% are employed, 10% are enrolled in training, and 73% are unemployed. We recognize that some of this age group are committed to domestic obligations, others may have given up.
- The average age of death in 1985 was 32.05 years.
- In 1985, off reservation residential treatment served 70 people (3 were under the age of 18) at a cost of 539,125 dollars.

There were many other such statistics. We are pleased to report that our Reservation has not had any alcohol related traffic fatality in over a year. However, 43% of auto accident injuries are alcohol related. We are making progress yet much work needs to be done.

We have reviewed and analyzed HR-1156. We would like to make the following recommendations:

TITLE I Interdepartmental Agreement

We recommend including the Secretary of Education to recognize the obligation and responsibility of the education community under Section 504 of the Rehabilitation Act and the Education of All Handicapped Children Act.

TITLE II Education

We recommend language that will not limit the responsibility to a few specific categorical programs as the principal source and base of this mandate.

TITLE IV Law Enforcement

> In addition to the arrest and follow-up provisions, drug and alcohol availability needs to be addressed by adding language to improve interagency action for "supply side" and "demand side" enforcement.

Drug and alcohol abuse is a major concern of our peers, both Indian and non-Indian. Substance abuse by itself is only a symptom. We request that Congress and the Administration pursue an interagency initiative to work cooperatively on solving the causes. A conceptual approach has been included with our statement. The approach can be expanded to establish a Federal interagency planning forum to ensure the best utilization of badly needed but diminishing financial resources working together we can make a difference.

In closing, we again want to express our most sincere appreciation for this honor to appear before you. Thank you for placing value on our thoughts and opinions.

Do you have any questions?

SYNOPSIS

This paper suggests that Indian tribes and communities take the initiative to develop a process to address long-range policy and program planning objectives for Indian education. It proposes that the established regional education laboratories in the United States provide coordination for this effort in order to have a neutral forum for tribal-federal deliberations and to capitalize on the laboratories' collective expertise in designing and operating model education services and systems.

DISCUSSION DRAFT 2

SETTING A NEW COURSE TO GUIDE INDIAN EDUCATION

A Cohesive Indian Education Policy Framework Is Needed

In his new Indian policy, President Reagan calls on tribes to assume greater responsibility for charting their own courses in human, resource, and economic development. Because the policy only outlines the principles which the Reagan administration endorses, it offers Indian tribes a significant opportunity to help shape federal Indian education policy and program standards. Education is key to tribes' attaining greater self-sufficiency. But how can tribes best meet the President's challenge through the existing education resources and systems which serve their students? And how can tribes foster a climate for constructive planning, coordination, and communication in Indian education?

Many aspects of an Indian education policy framework already exist, but the pieces are fragmented. And innumerable national studies and reports have extensively analyzed Indian education needs from every perspective. All these elements need to be assembled and advanced methodically, not merely reviewed and rehashed.

For years, Congress has guided the evolution of federal Indian education policies through legislation like the Indian Education Act of 1982, the Indian Self-Determination and Education Assistance Act of 1975, the Indian Health Care and Improvement Act of 1976, Title XI of the Education Amendments Act of 1978, and the Tribally-Controlled Community Colleges Act of 1978. Each of these federal laws has sought to strengthen the quality of education services provided Indian students and to increase the involvement of Indian communities and parents in education programs.

The Title XI provisions of the Education Amendments Act of 1978 (P.O. 95-561) represent the most recent broad federal policy for Indian Edcuation. This Act mandated that the BIA develop national standards for federal and tribally-controlled schools serving Indian students. It extended the Indian Education Act of 1972 for five years. It reorganized BIA education operations. And it increased the Impact Aid entitlements for schools with Indian students living on reservations. The Act also required that Indian tribes and parents be afforded greater involvement in planning and monitoring basic education services for their students.

However, the 1978 amendments did not set a comprehensive federal Indian education policy framework, nor did it fully describe the relative roles in Indian education which tribal, state, local, and federal governments should play. It did provide some direction for moving towards these goals, but it did not reach them.

Because no policy framework exists in Indian education and because no general standards have been developed to measure how well the policy is being carried out, Indian education interests often have been left to react to, rather than to help create, the education systems and services set up for them.

Comprehensive Indian Education Standards Must Be Set

What planning now takes place in Indian education is basically short-term and disjointed. By and large, Indian education services operate on annual budget cycles and under one-year program constraints. Indian education programs are often required to get by on tentative, short-term allocations. If they limit their programs, they may have large surpluses at the end of the year. If they do not, they may have large assessments which must be repaid in future years. Obviously, this practical dilemma effectively precludes long-range planning. There is neither much opportunity nor much incentive to look beyond the next year.

If Indian education is ever to break out of the short-term cycles that plague its progress. Indian tribes and communities must take the initiative to decide the direction that Indian education should take and to define how all the available resources can be tied together most effectively. To achieve this objective, Indian tribes and communities must join together to establish a new forum in which their individual goals and needs can be discussed and out of which general objectives can be formulated. Whatever process is used, it should encourage constructive dialogue among all Indian education interests, and it should emphasize pragmatic recommendations that can provide the direction needed for tribal, federal, state, and local Indian education services. Among the critical issues which need attention are the following:

* The draft BIA standards for Indian education and their relation to long-range quality programs.

* The role of BIA off-reservation boarding schools in furnishing quality Indian education programs.

* The role of state governments and public school districts in Indian education.

* The role of tribal governments and the federal government in Indian education.

* Innovative education programs that could be successfully adapted to the present systems which support Indian education.

In developing common strategies to address these issues, Indian tribes and communities will need to demonstrate that their diverse interests can be reconciled towards constructive, long-term objectives for Indian education. Ultimately, the success of this effort will depend on the participation and support it receives from a braod cross-section of Indian education interests and on the quality of the products it can put forth.

Initiating A Process To Achieve Positive Results

To tie these needs for a policy framework and program standard in Indian education together, the Confederated Tribes of the Warm Springs Reservation of Oregon calls on other tribes and Indian communities to join us in establishing a new course for Indian education. We are convinced that our collective efforts can provide the long-range direction which has been lacking in Indian edcuation for too long. As a starting point for discussion, we propose the following outline for action:

* Interested tribes and other Indian communities would initiate a request that the directors of the seven regional education laboratories through the United States serve as a coordinating council between federal Indian education agencies and Indian tribes or communities.

* If they agreed to so serve, the directors would develop a proposed work plan to carry out their tasks. This work plan would be referred back to the participating tribal and Indian education organizations for their review and endorsement.

* The coordinating council would be responsible for identifying the present direction in federal Indian education services through consultation with the Bureau of Indian Affairs and the Department of Education.

* The coordinating council would communicate these findings to Indian tribes and communities through a series of regional seminars and would solicit suggestions about ways Indian people believe the present direction could be modified to provide improved Indian education services in future years.

* These tribal and community perspectives would be reported back to the Bureau of Indian Affairs and the Department of Education for their review and analysis.

* A national convocation on Indian education would be sponsored by the coordinating council to allow for

discussion of the direction in Indian education desired by Indian people and the ability of the federal goverment to support this direction.

* The coordinating council would publish these proceedings and identify those issues resolved, those not resolved, and those requiring further consideration.

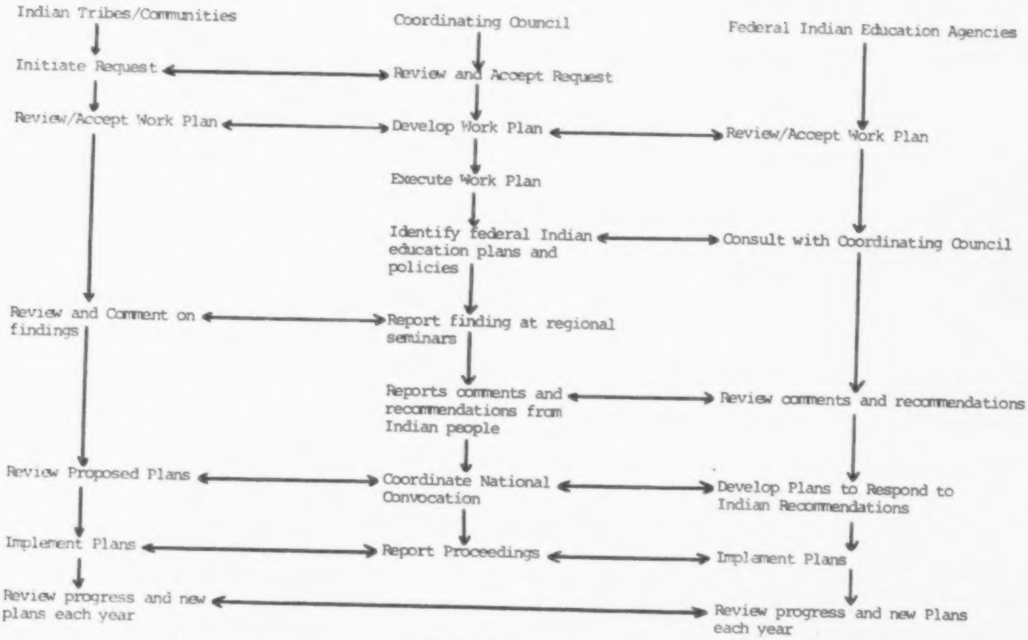
* The BIA and the Department of Education would develop annual plans responding to the needs and concerns they agree to address, and they would provide periodic reports of their progress in these areas.

A preliminary flow chart that portrays how this process could work is attached.

We believe this approach will provide needed objectivity and educational expertise in developing long-range Indian education policies and plans. We also believe that it will provide a vehicle which Indian tribes and the federal government can support to begin a constructive dialogue on their respective Indian education interests.

A NEW COURSE FOR INDIAN EDUCATION

FLOW CHART OF PROPOSED PROCESS


Indian Tribes/Communities
Coordinating Council
Federal Indian Education Agencies
Initiate Request
Review and Accept Request
Review/Accept Work Plan
Develop Work Plan
Review/Accept Work Plan
Execute Work Plan
Identify federal Indian education plans and policies
Consult with Coordinating Council
Review and Comment on findings
Report finding at regional seminars
Reports comments and recommendations from Indian people
Review comments and recommendations
Review Proposed Plans
Coordinate National Convocation
Develop Plans to Respond to Indian Recommendations
Implement Plans
Report Proceedings
Implement Plans
Review progress and new plans each year
Review progress and new Plans each year

UTE INDIAN TRIBE
UINTAH AND OURAY AGENCY
Fort Duchesne, Utah 84026

In Reply: (801) 722-5141

Testimony on H.R. 1156

"Indian Juvenile Alcohol and Drug Abuse Prevention Act"

My name is Jason Wyasket. I am a member of the Youth Committee representing the Ute Indian Tribe of the Uintah and Ouray Reservation, Utah. Also with me are Pearleen Ridley and Thorton Serawop.

I want to take this time to thank the members of this committee for the opportunity to appear here today.

We three are representatives of the younger generation of the Northern Ute Indian Tribe of Utah and we would like to express our opinions and concerns regarding the H. R. 1156 Bill "Indian Juvenile Alcohol and Drug Abuse Prevention Act." The youth of the Northern Ute Indian Tribe of Utah fully support the intent of the bill being presented at this time.

It has been our observation that at the Uintah and Ouray Reservation there is a great need for the Bill, so that it can provide alternatives for the future generation besides abusing drugs and alcohol. It is our feeling that if there were to be trained personnel in the various areas of drug and alcohol abuse by the youth, they could provide substantial impact on this problem we encounter.

We also feel if trained adults were to set up a program, including meetings and workshops to inform parents, and if the younger people are properly educated about problems relating to drug and alcohol abuse they would be able to say no.

The youth have few alternatives to drugs and alcohol. They need other choices that include parental involvement. Education could provide a start at an early age in providing alternative methods.

We believe that many educational institutions have physical fitness programs. Quote stated from People Magazine, April 14, 1986 Edition by George Allen, former Washington Redskins Football Coach, "Only 36% of all students have physical education classes daily. In 1964, 90% of all tenth grade students had Physical Education class. Today, only 69% of all tenth grade students have this same class." This decline could be attributed to the fact that reduced funding from State and Federal levels has led to the tightening of budgets and one of the first things to go is Physical Education. Therefore, the class of Physical Education is in jeopardy of being cut out. This eliminates one of the few choices that we are allowed.

It is in the opinion of the youth we represent that programs emphasizing the importance of a good physical fitness programs to be coupled with a drug and alcohol abuse prevention program would provide an expansion in the overall outlook of this Bill.

We had concerns about the Title II-Education Section 201, Section 304 of the Indian Elementary and Secondary School Assistance Act calling for the adding of and I quote..."(3) the training of counselors at school eligible for funding under this title in counseling techniques relevant to alcohol and drug abuse." What would happen to the schools not eligible for this funding? Because of the economy and continuing changes in governmental polocy on our reservation we may soon be facing the problem of not being eligible through our educational system. Who or whatever resource do we turn too for assistance.

Also, under the same title, Section 203, Section 315 (a) of the Adult Education Act and again I quote from Amendment 6 "to provide alcohol and drug abuse counseling services to better enable Indians in need of such services to take advantages of educational and employment opportunities."

We feel that the services have always been there and that the people have never seen any reason to take advantage of these opportunities. Because of this lack of cooperation it is our opinion that we must, in some way, fight this problem that faces us and many other reservations across the United States.

In regards to Section 204 (a) concerning the provision of a program of instruction regarding alcohol and drug abuse to students in kindergarten and grades 1-12, we feel that if these services were to be expanded to include from Head Start age to beyond 12th grade, through employer efforts they would be required to attend and by expanding these services beyond the normal realm of education, many of the Indian youth would be able to receive these services that they normally would not have been able to.

Also, in the same Title, Section 204 (b) should be changed from, and I quote... "school providing programs of instruction under subsection (a) are encouraged to emphasize family participation in such instruction" to state... "are required to have family participation whenever possible in such instruction." By doing this, it would increase parental involvement and help to reduce the useage of alcohol and drugs.

In Section 205 (a) (1) (2) (3) concerning programs of Indian youth in the summer. It has been our personal experience that these programs, as presented at the Uintah and Ouray Reservation, have not been proven effective. But it is in the opinion of the youth we represent, that if these activities were to be monitored it would greatly increase the effectiveness and would act as a substitute for drugs and alcohol.

We are in total agreement with the Section that provides for emergency shelters. This would be an excellent alternative to jail because it would provide necessary rehabilitation needed in most cases.

The overall outlook of H. R. 1156 has been viewed favorably by the tribal youth we represent. We feel that all tribes would benefit from the passing of Bill H. R. 1156, we believe that the Bureau of Indian Affairs and Indian Health Services would provide adequate services.

Suggestions have been made that recreational funds be provided for communities where the youth could plan games and other activities to help youth understand and deal with this problem in a more peer emphasized program. Include some classes about drug abuse and see what personalities are involved. (1) Maybe they have a low-self esteem. (2) Being unable to live up to their goals and expectations and (3) No one to talk to about the problems they are facing.

We, the youth, are willing to help get other youth off drugs and get them high on life.

Parents need to help their children copy with their problems and encourage them to get a good education and be able to say "no" when they need too.

Many believe they don't have to listen to their parents concerning the importance of an education and law.

If we had more programs to show the younger generation how alcohol and drugs could affect them and others, perhaps they'll have a greater view of the problem.

Alcohol is affecting our tribe and not in a positive way. Our older people have depended on alcohol and many have died for this reason. But, our younger people fail to recognize the future of where their drinking will lead.

These programs, we feel will give better understanding about how alcohol and drug abuse affect our younger people and prevent this vicious cycle from continuing.

We feel that the alternatives that would aid in the battle against these substances and the recreational facilities and funds are not adequate enough to fulfill these needs.

If our facilities were improved and trained adults were to create a program that could not just get people interested but could provide a greatly needed alternative to the use of drugs and alcohol.

It is the general concensus of not only the youth of the tribe, but many respected adults, that the only true resolution to this problem is that the parents get involved and support their children in everything positive that they do.

In conclusion... we feel that through this Bill a general starting point for youth in the right direction could be established and that the results, and changes in the Indian youth could really be accounted for. First, we could be starting a firm foundation for the children and that would be utilizing every effort to control the use of these substances in the years to come. So, it is in the opinion of the youth we represent, that we recommend this Bill to be passed and we as a tribe, as Indian people, as a whole nation will be able to help our future brothers and sisters. That we will all benefit from it. We would like to thank the House Committee on Interior and Indian Affairs for giving us this time and opportunity to express the views of the Ute Indian Tribe Youth on the H. R. 1156 "Indian Juvenile Alcohol and Drug Abuse Prevention Act." Thank you.

Respectfully submitted:

Youth Committee representing the Ute Indian Tribe
of the Uintah and Ouray Reservation of Utah

WRITTEN TESTIMONY

on

H.R. 1156, THE INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT

Submitted to:

HONORABLE MORRIS UDALL, CHAIRMAN
COMMITTEE ON INTERIOR AND INSULAR AFFAIRS
U.S. House of Representatives
Washington DC 20515

by:

KENNETH GRANT, SENIOR CLASS PRESIDENT
CHOCTAW CENTRAL HIGH SCHOOL
MISSISSIPPI BAND OF CHOCTAW INDIANS
Route 7 Box 21
Philadelphia MS 39350

April 29, 1986

My name is Kenneth Grant, and I am the President of the Senior Class at Choctaw Central High School, a Bureau of Indian Affairs-administered secondary school serving the members of the Mississippi Band of Choctaw Indians in east central Mississippi. The tribe has some 4,500 members living on or near 18,000 acres of trust land in six counties. Total enrollment in the BIA schools on reservation (there are six elementary schools and a middle school in addition to the high school) is 1,200.

The need for H.R. 1156 or similar legislation is very great in Indian Country. Indian students face unique pressures other American young people do not face as a general group, including the rural isolation of reservation life, English as a second language, low expectations in the Bureau schools, and low self-images, all of which conspire to encourage patterns of substance abuse.

The tribe recently conducted a major study of self-images on the Choctaw reservation, administering a questionnaire to 339 randomly selected reservation residents, 196 of them high school students. The survey included several items designed to determine role models for students in order to determine whether these role models would be Indian or non-Indian. What the study found, instead, was that 69.4 per cent of the respondants had no role models at all. According to mental health specialists, a major developmental task of adolescence is the identification of adult role models who can assist students in understanding adult responsibilities. The apathy and despair that the lack of role models suggests is a breeding ground for the use and abuse of alcohol and drugs.

As might be expected, the survey found that 62 per cent of the students use alcohol in one form or another, and that the percentage increases with the age of the student. Even more surprisingly for a reservation setting, the survey revealed that 35 per cent of the students had used marijuana, and 37.7 per cent said they knew someone who had used drugs other than marijuana. Clearly, though drug problems may have taken a number of years to reach the reservation, they are there now.

The linkage of these statistics to teen suicide is readily apparent. The survey found that suicide inclination averages at 31.7 per cent among all the high school students, but that the percentage increased with age and was markedly more serious among members of the junior and senior class.

The tribal government, the BIA, and the IHS are all ill-equipped to deal with a problem of this magnitude. Public Law 95-561 has restricted the resources going to counseling in the schools, and mental health funding through the Indian Health Service is severly constrained. The lack, perhaps, of these "first-step" services has led a number of young people on the reservation to further deterioration of their lives and troubles with the law. Yet there is no juvenile facility on the reservation, a bill in the Mississippi State Legislature to permit the tribe to use state juvenile facilities died in committee, and young people in trouble are thus free to roam at will.

I do not think we need examine the issue of whether agencies are already addressing these problems, because clearly they are not, and the problems are rapidly growing. Indian young people have unique needs that are not being addressed, and the federal government has as much of a unique responsibility to them as it does to Indian adults.